

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09385

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 41 years  
Hospital, institution, or street address where death occurred:  
234 Jefferson St.  
How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 234 Jefferson St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

George A. Baker

3. (b) Social Security Number

160-16-0231

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 31, 1905

8. AGE: Years 41 Months 11 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown Washington Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Grey Concret Workd.

12. Name Welly I. Baker

13. Birthplace Hagerstown Md.

14. Maiden name Belle Shaffner

15. Birthplace Waynesboro Pa.

16. Informant Mrs. Belle Baker  
Address Hagerstown Md.

17. Burial Date thereof Oct. 6, 1947  
(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son  
Address Hagerstown Md.

19. Oct. 6, 47 Registrar C. H. Powers  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1947 at 4 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2, 1947 to Oct 4, 1947  
and that I last saw him alive on Oct 4 - 47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Congestive Heart Failure 2 Months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic alcoholic

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

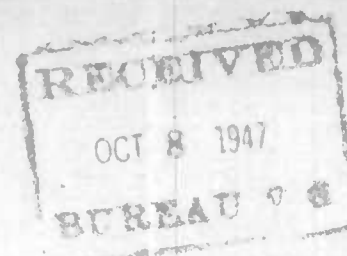
23. SIGNATURE C. H. Powers M. D. or other \_\_\_\_\_

Address Hagerstown Date signed 10/4/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09386

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life Resident  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 138 E. Washington Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jeremiah Wesley Barncord

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Vertie L. Barncord  
 7. Birth date of deceased (mo., day, yr.) June 25, 1885  
 6.(c) If alive, give age ..... years  
 8. AGE: Years 62 Months 3 Days 9 If less than one day  
 ..... hrs. .... min.

9. Birthplace Hagerstown, Wash. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Real Estate Dealer  
 11. Industry or business

MOTHER FATHER  
 12. Name Jacob Barncord  
 13. Birthplace Washington County, Md.  
 14. Maiden name Sarah Dennis  
 15. Birthplace Washington County, Md.

16. Informant Mrs. Vertie L. Barncord  
 Address 138 E. Wash. St. Hagerstown, Md

17. Burial Date thereof Oct. 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. Oct. 7, 1947 Black Power  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1947 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 18 1946 to Oct 4 1947  
 and that I last saw him alive on Oct 4 1947

Immediate cause of death

DURATION

Cerebral hemorrhage 9/29/47  
Atherosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. L. Porterfield M.D. M.D. or otherAddress 136 W Washington Date signed 10/6/47

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OCT 9 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

69514

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown Route #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Days  
 Hospital, institution, or street address where death occurred:  
Layman Nursing Home  
 How long in hospital or institution? 2 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 841 Maryland Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS IDA BELLE BEALE

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Beale

7. Birth date of deceased (mo., day, yr.) Sept. 21 - 1866  
 6. (c) If alive, give age -- years

8. AGE: Years 82 Months 11 Days 28 If less than one day hrs. min.

9. Birthplace Berkley Springs Morgan Co. W.  
 (Town, county, and state)

10. Usual occupation House Wife11. Industry or business Own Home12. Name William Yost13. Birthplace Berkley Springs W. Va.14. Maiden name Jane Widkyer15. Birthplace Berkley Springs W. Va.16. Informant Mrs. Bertha DiffendallAddress Hagerstown Md.

17. Burial Date thereof 10/22/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. 10-21- 19 47 Robert L. Elder

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH October 19 19 47 at 10:4521. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 19 43 to Oct. 19 19 47and that I last saw him alive on Oct. 16, 1947 19 47Immediate cause of death aspiration pneumonia

DURATION

4 yrsDue to kind unknownDue to aspiration pneumonia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE S. Robert Wells M.D.Address Hagerstown, Md. Date signed 10/20/47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 mo.

Hospital, institution, or street address where death occurred:

Barlock Nursing Home  
How long in hospital or institution? 8 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County FranklinCity or town State Line  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

Willie Beard

## 3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Robert Beard

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 21 - 18678. AGE: Years 80 Months 4 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace State Line Penn.  
(Town, county, and state)10. Usual occupation House wife11. Industry or business Own Home12. Name George Sossard13. Birthplace Pennsylvania14. Maiden name Louisa Weaver15. Birthplace no record16. Informant Mrs. Robert ZellusAddress Boonsboro Md17. Burial Date thereof Oct. 22, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beautiful View CemeteryLocation State Line Penn.18. Funeral director Chas. J. Bost & SonsAddress Boonsboro Md19. Oct. 21, 1947 Chas. J. Bost & Sons  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1947 at 6:25 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1946 to October 20 1947and that I last saw him alive on Oct. 19 1947Immediate cause of death Coronary ThrombosisDURATION  
5 daysDue to Arterial Hypertension1 yr. 8 mos. 17 d.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mens of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Hubert Wade M.D.  
M. D. or other \_\_\_\_\_Address Boonsboro Md Date signed 10/20/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-12

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. Wade

09387

38-

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OCT 23 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09388

Reg. Dist. No. 303

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH:</b><br>County... <u>Washington</u><br>City or town... <u>Big Pool, Md.</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death? <u>Life</u><br>Hospital, institution, or street address where death occurred:<br>How long in hospital or institution? |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(For newborn infants give residence of mother)<br>State... <u>Maryland</u> County... <u>Washington</u><br>City or town... <u>Big Pool, Md.</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No.<br>(If rural, give LOCATION)<br>2.(a) If veteran, name war |  |   |  |
| <b>3. (a) FULL NAME</b><br><u>Mary Ellen Brewer</u>  |  |  |  | <b>3. (b) Social Security Number</b>  |  |   |  |
| <b>4. Sex</b><br><u>Female</u>   |  | <b>5. Color or race</b><br><u>White</u>  |  | <b>6. (a) Single, married, widowed, or divorced</b><br><u>Widowed</u>   |  | <b>MEDICAL CERTIFICATION</b><br><b>2D. DATE OF DEATH</b> ... <u>October 8</u> ... <u>1947</u> ... at <u>5:40 P.M.</u> |  |
| <b>6. (b) Name of husband or wife</b> ... <u>George Brewer</u><br>6. (c) If alive, give age... years   |  |  |  | <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>April</u> 19 <u>46</u> , to <u>Oct. 8</u> 19 <u>47</u><br>and that I last saw him alive on <u>Oct 8</u> 19 <u>47</u><br>Immediate cause of death... <u>Coronary Thrombosis</u> DURATION <u>2 days</u>                                       |  |   |  |
| <b>7. Birth date of deceased (mo., day, yr.)</b><br><u>July 29, 1864</u>   |  | <b>8. AGE:</b> Years <u>83</u> Months <u>1</u> Days <u>7</u> If less than one day... hrs. min.   |  | Due to... <u>Arterio Sclerosis</u> 10 yrs.<br>Due to...<br>Other conditions... <u>Fractured Femur due to fall in 1945</u> 1 1/2 yrs.<br>(Include pregnancy within 3 months of death)  |  |   |  |
| <b>9. Birthplace</b> ... <u>Washington Co. Md.</u><br>(Town, county, and state)  |  |  |  | <b>Major findings of operations</b> ... Date of op.   |  |   |  |
| <b>10. Usual occupation</b> ... <u>Home duties</u>   |  |  |  | <b>Autopsy results</b> ...<br><b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>  |  |   |  |
| <b>11. Industry or business</b>  |  |  |  | <b>22. VIOLENCE: If death was due to external causes, fill in the following:</b><br>Accident, suicide, or homicide... Date of...<br>Where did injury occur? (City or town) (County) (State)<br>Injured at home, farm, industry, public place (where?)<br>Means of injury Injured at work?   |  |   |  |
| <b>MOTHER</b><br><b>12. Name</b> ... <u>Jacob Tedrick</u><br><b>13. Birthplace</b> ... <u>Washington Co. Md.</u><br><b>14. Maiden name</b> ... <u>Ann Tice</u><br><b>15. Birthplace</b> ... <u>Wash. Co. Md.</u>   |  | <b>FATHER</b><br><b>16. Informant</b> ... <u>George L. Brewer</u><br>Address... <u>Big Pool, Md.</u><br><u>Burial</u> Date thereof... <u>Oct. 11, 1947</u><br>(Burial, cremation, or removal. Which?) (month) (day) (year)<br>Cemetery or crematory... <u>Shantown Cemetery</u><br>Location... <u>Big Pool, Md.</u><br>18. Funeral director... <u>Snyder-Rowland</u><br>Address... <u>Hancock, Md.</u> |  | <b>23. SIGNATURE</b> ... <u>David P. Brewer M.D.</u> M. D. or other<br>Address... <u>Clear Spring Md.</u> Date signed... <u>10/10/47</u>  |  |   |  |
| <b>19. (Date rec'd by registrar)</b> ... <u>October 10, 1947</u> <u>Joseph W. Murray</u> Registrar   |  |  |  |   |  |   |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09389  
Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
County Hagerstown  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 76 years  
Hospital, institution, or street address where death occurred:  
158 W. Jonathan St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 35 W. North Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war

## 3. (a) FULL NAME

James Fernley Brown

## 3. (b) Social Security Number

220-16-0364

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mrs. Marguerite Brown  
6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) December 1, 1900

8. AGE: Years 46 Months 10 Days 11 If less than one day  
..... hrs. .... min.

9. Birthplace Hagerstown, Wash. Ind.  
(Town, county, and state)

10. Usual occupation

11. Industry or business Restaurant Operator

12. Name Harry Jones

13. Birthplace Hagerstown, Md.

14. Maiden name Mary Brown

15. Birthplace Hagerstown, Md.

16. Informant Mrs. Marguerite Brown

Address 35 W. North Street

17. Burial Date thereof 10/15/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director William H. Downey

Address 291 Frederick St. Hagerstown

19. Oct. 15, 47 Registrar G. B. H. Brown  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1947 at 8:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19....., to..... 19.....  
and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Gunshot wound through chest & ventricle

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Ante-mortem results..... Date of op. 10/13/47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 10/12/47

Where did injury occur? Hagerstown, Wash. Ind.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gunshot wound Injured at work? No

DEPUTY MEDICAL EXAM. Dr. Robert Wells WASH. CO., MD.

23. SIGNATURE..... M. D. other

Address Hagerstown, Md. Date signed 10/14/47

Washington  
Department of the Interior  
Bureau of Land Management

Washington  
Department of the Interior  
Bureau of Land Management

James F. Kelly, Bureau

These are the  
The Department of the Interior  
#4

October 1, 1947

to the  
Department of the Interior

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BUREAU OF LAND MANAGEMENT

These are the  
The Department of the Interior  
Bureau of Land Management  
10/15/47  
Bureau of Land Management  
Washington, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Hornbaker

09390

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Years  
 Hospital, institution, or street address where death occurred:  
116 N. Mulberry St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 116 N. Mulberry St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War #1 307th Eng.

## 3. (a) FULL NAME

TRACY BOLTON CALHOUN

## 3. (b) Social Security Number

214-09-3056

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Elizabeth  
 6. (c) If alive, give age 55 years  
 7. Birth date of deceased (mo., day, yr.) September 18, 1892  
 8. AGE: Years 55 Months 1 Days 2 If less than one day  
 hrs. min.

9. Birthplace North River, Rockingham Co., Va.  
(Town, county, and state)10. Usual occupation Night Foreman11. Industry or business D. A. Stickel & Son12. Name James W. Calhoun13. Birthplace North River Va.14. Maiden name Martha Crabill15. Birthplace North River Va.16. Informant Mrs. Elizabeth CalhounAddress Hagerstown Md.17. Burial Date thereof 10/23/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 23, 47 Booth Powers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1947 at 7:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Oct. 20, 1947and that I last saw him alive on Oct. 20, 1947

Immediate cause of death

acute coronary occlusionDURATION  
Dropped  
DeadDue to arteriosclerosis of coronaryarteries (had acute coronaryDue to occlusion May 1945)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Hornbaker, M.D.Address 154 W. Washington St. Hagerstown Md. Date signed 10/21/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

09391

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 Years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 334 Vista St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS ADELINI C. CASTELUCCI

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Biagio Castelucci  
 7. Birth date of deceased (mo., day, yr.) March 3, 1903 6.(c) If alive, give age 46 years  
 8. AGE: Years 44 Months 7 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rome Italy  
 (Town, county, and state)  
 10. Usual occupation House Wife  
 11. Industry or business Own Home  
 12. Name Antonio Calendrella  
 13. Birthplace Italy  
 14. Maiden name Columbia Loubbia  
 15. Birthplace Italy

16. Informant Biagio Castelucci  
 Address Hagerstown Md.  
 17. Burial Burial Date thereof 10/20/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Oct. 19, 47 Blanch Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1947 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1-47 19 to Oct 17-47 19  
 and that I last saw him alive on Oct 17-47 19

Immediate cause of death gangrene leg - extensive resection 2 wh  
 DURATION 10 yrs

Due to Ischemia  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

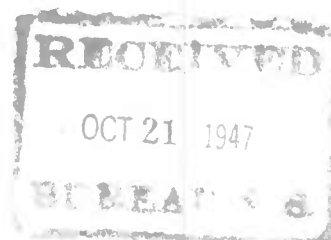
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. SW Ditto M. D. or other \_\_\_\_\_Address Hagerstown Md Date signed 10/19/47





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0939305-  
203-  
Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County.....Washington  
City or town.....Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....1 yr. 3 mos.  
Hospital, institution, or street address where death occurred:  
Maryland State Reformatory for Males  
How long in hospital or institution?.....1 yr. 3 mos.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....Maryland County.....Washington  
City or town.....Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....918 N. Parrish St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....None ✓

### 3. (a) FULL NAME

Lloyd Chase

3. (b) Social Security Number  
216-20-6923

4. Sex.....Male 5. Color or race.....Negro 6. (a) Single, married, widowed, or divorced.....Single

B. (b) Name of husband or wife.....— 6. (c) If alive, give age.....— years

7. Birth date of deceased (mo., day, yr.).....March 19, 1928

8. AGE: Years.....19 Months.....6 Days.....21 If less than one day..... hrs. .... min.

9. Birthplace.....Baltimore, Md.  
(Town, county, and state)

10. Usual occupation.....Chauffeur

11. Industry or business.....

12. Name.....Richard Chase

13. Birthplace.....Baltimore, Maryland

14. Maiden name.....Roye Jones

15. Birthplace.....Baltimore, Maryland

16. Informant.....Maryland State Reformatory For

Address.....Breathedsville, Maryland

17. Burial.....Oct. 13/47  
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory.....Mt. Auburn Cemetery

Location.....Baltimore, Maryland

18. Funeral director.....Andrew K. Coffman

Address.....Hagerstown, Md.

19. Oct. 10, 1947 John H. Back  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....October 10, 1947 at 5:27 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Oct 10 1947 and that I last saw him alive on Oct 9 1947

Immediate cause of death.....

Pulm. Tuberculosis DURATION.....1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Robert P. Conrad, M.D.

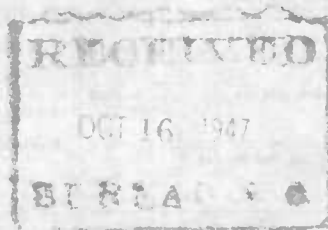
Address.....Hagerstown, Md. M. D. or other

Date signed.....10-10-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural--Sharpsburg, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 47 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Rural--Sharpsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Jennings Bryan Crampton

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Margaret P. Crampton  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 25, 1900  
 8. AGE: Years 47 Months 2 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Antietam-Wash.-Maryland  
 (Town, county, and state)  
 10. Usual occupation Merchant  
 11. Industry or business  
 12. Name Thomas Crampton  
 13. Birthplace Antietam-Maryland  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant Mrs. Margaret P. Crampton  
 Address Sharpsburg, Md. R. F. D. #2  
 17. Burial Date thereof Oct. 8, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. View  
 Location Sharpsburg--Maryland  
 18. Funeral director R. I. Earnshaw  
 Address Keedysville, Md  
 19. 10-7 19 47  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 19 47 at 6:30 A. M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 19 47 to Oct 6 19 47  
 and that I last saw him alive on Oct 5 19 47  
 Immediate cause of death Angina Pectoris  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE G. W. Selman M.D.  
 Address Barnabrook Date signed 10/6/47

RECEIVED

NOV 20 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 years  
 Hospital, institution, or street address where death occurred:  
Homewood Church Home  
 How long in hospital or institution?..... 3 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1823 Virginia Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Minnie P. Deardorff

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... September 24, 1878

8. AGE: Years..... 69 Months..... 5 Days..... 11 If less than one day..... hrs. .... min.

9. Birthplace..... Newport, Pa.  
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business.....

12. Name..... Not Known

13. Birthplace.....

14. Maiden name..... Not Known

15. Birthplace.....

16. Informant..... Rev. W. B. Hartzell  
Hagerstown, Maryland  
 Address

17. Removal Date thereof..... 10-7-47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Newport Cemetery  
 Location..... Newport, Pa.

18. Funeral director..... C. M. Suter & Sons  
Hagerstown, Maryland  
 Address

19. Oct. 6, 47 W. H. Flowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 5-47 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct 4-47 19..... to Oct 5-47 19.....  
 and that I last saw him alive on Oct 4-47 19.....

Immediate cause of death.....  
Coronary Thrombosis

Due to.....  
one week

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. E. W. Suter M. D. or other  
Hagerstown Address..... Date signed..... 10/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

A. DEATH

1. SEX AND RACE

RECEIVED

OCT 8 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/02

09394

7

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 HoursHospital, institution, or street address where death occurred:  
Washington County HospitalHow long in hospital or institution? 12 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Taylor's Landing  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

DENNIS Alvey Canfield

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ida May6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) August 7 18748. AGE: Years Months Days If less than one day  
73 1 27 .....hrs. ....min.9. Birthplace Grafton Taylor Co W. Va.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Benj. Franklin Canfield13. Birthplace Roanoke Va.14. Maiden name Mary Eliz Coffman15. Birthplace Phillippy W. Va.16. Informant Mrs. Ida M. CanfieldAddress Sharpsburg Md. R.F.D.17. Burial Date thereof 10/7/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 7. 47 Shirley Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 19 47, at 11 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 20 19 47, to Oct. 4 19 47,  
and that I last saw him alive on Oct. 4, 1947.Immediate cause of death cardio-vascular-renal disease DURATION 1 Yr.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

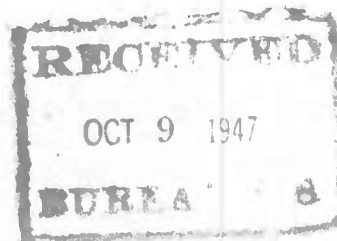
Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Walter H. Shealy M.D. M. D. or otherAddress Sharpsburg, Md. Date signed .....





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Reg. Dist. No.

69516

300

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural Sharsburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Rural Sharsburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Albert L. Dieterich

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Sara Jane Dixon  
 7. Birth date of deceased (mo., day, yr.) April 22<sup>nd</sup> 1872 6. (c) If alive, give age 67 years  
 8. AGE: Years 75 Months 5 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Melchor B. Dieterich

13. Birthplace Penna

14. Maiden name Susan Ann Brubaker

15. Birthplace Penna.

16. Informant L. F. Reicher Sarah Dieterich

Address Hunkstown Md.

17. Burial Date thereof 10/18/47  
 (Burial, cremation, or removal. Which?) (month) (day) (Year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Md.

18. Funeral director L. F. Reicher

Address Hunkstown Md.

19. 10-16 19 47 Elmer J. Bayes  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947 at 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Oct. 16 1947.  
 and that I last saw him alive on Oct. 1 1947.

Immediate cause of death Wrenia DURATION 2 months

Due to Cardio-vascular 1 yr. +  
Renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Shealy M.D. M. D. or other

Address Sharsburg, Md. Date signed 10/16/47

RECEIVED

NOV 20 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. And correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. wells

09395

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R # 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
Huyetts Cross Roads  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R # 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Huyetts Cross roads  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

HARRY BLAINE DORSEY

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Grace Buchanan

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age 58 years

January 1 1885

8. AGE: Years Months Days If less than one day

62 9 20 hrs. min.

9. Birthplace Downsville Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Retired

12. Name John M. Dorsey

13. Birthplace Downsville Md.

14. Maiden name Elizabeth Roe

15. Birthplace Downsville Md.

16. Informant Mrs. Grace Dorsey

Address Hagerstown Md. R # 2

17. Burial Date thereof 10/23/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dunkard Cemetery

Location Broadfording Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 23. 1947 47 Shachtz Bowers  
(Data rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947 19 al 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death. DURATION

Vascular hypertension 3 yrs  
 Due to cerebral hemorrhage 18 Hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. none

Date of op.

Autopsy results. none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAMINER  
WASH. CO., MD.Address Hagerstown, Md. Date signed 10/21/47

RECEIVED

OCT 25 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09396

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred: Washington County Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 406 N. Jonathan Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs. Maude Dorsey Ford

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Charles Ford

## 7. Birth date of deceased (mo., day, yr.)

June 19, 1880

## 6. (c) If alive, give age

86 years

## 8. AGE:

67 Years

## Months

4

## Days

9

## If less than one day

hrs.

min.

## 9. Birthplace

Hagerstown, Washington, Md.  
(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

John Thomas Dorsey

## 13. Birthplace

State Line, Pa.

## 14. Maiden name

Sarah Jane Doris

## 15. Birthplace

State Line, Pa.

## 16. Informant

Mr. Charles Ford

## Address

406 N. Jonathan Street

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

10/30/47  
(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Hagerstown, Md.

## 18. Funeral director

William H. Downey

## Address

291 Frederick St Hagerstown

## 19.

Oct. 30, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

28 Oct19 47at 12 noon

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 Oct19 47to 28 Oct19 47and that I last saw him alive on 28 Oct 19 47

## Immediate cause of death

Cerebral Anoxia

## DURATION

3 days

## Due to

## Due to

## Other conditions

Aspiration pneumonia

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Edm. S. H. Vardlaw, M.D.  
M. D. or other

## Address

Hagerstown, Md.

Date signed

29 Oct 47

# REPORT

NOV 1 1947

THE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If you are not sure of the correct age, please write the age of the deceased. Physicians: please write the causes of death clearly and legibly. This is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09397

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 8 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?..... 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 242 S. Potomac Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Katherine E. Frownfelter

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife.....

Charles E. Frownfelter

## 7. Birth date of deceased (mo., day, yr.)

November 7, 1879

## 6. (c) If alive, give age..... years

## 8. AGE:

Years  
67Months  
11Days  
22

If less than one day

..... hrs. .... min.

## 9. Birthplace.....

Clear Spring- Wash. Co., Md.  
(Town, county, and state)

## 10. Usual occupation.....

Home Duties

## 11. Industry or business

FATHER  
MOTHER

## 12. Name.....

Berkley Rohrer

## 13. Birthplace.....

Berkley County, W. Va.

## 14. Maiden name.....

Elizabeth Martin

## 15. Birthplace.....

Washington Co., Md.

## 16. Informant.....

John Yeakle

## Address.....

Clear Spring, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Oct. 31-47  
(month) (day) (year)

## Cemetery or crematory.....

St. Paul's Cemetery

## Location.....

Route 40 W.-Hagerstown, Md.

## 18. Funeral director.....

Fred W. Kraiss

## Address.....

Hagerstown, Md.

19. Oct. 31, 47

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 29, 1947 19..... at..... A.M.

## 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov 1-47 19..... to..... Oct 29 47  
 and that I last saw him alive on..... Oct 18-47 19.....

## Immediate cause of death.....

Cerebral Hemorrhage

## DURATION

## Due to.....

## Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op. ....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

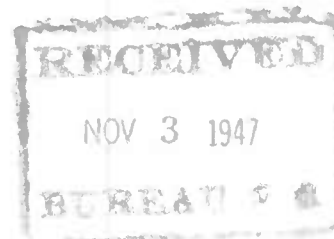
Injured at work?

## 23. SIGNATURE.....

Address.....

M. D. ....

Date signed.....





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Campbell

09398

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 minutes  
 Hospital, institution, or street address where death occurred:  
Washington county hospital  
 How long in hospital or institution? 20 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 10 No. Mulberry St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS VERONICA VIOLA GALLOWAY

## 3. (b) Social Security Number

None

|   |                                      |  |      |
|---|--------------------------------------|--|------|
| 4. Sex  | 5. Color or race                     | 6. (a) Single, married, widowed, or divorced |      |
| Female  | White                                | Widow  |      |
| 6. (b) Name of husband or wife <u>Thomas H.</u>   |                                      |  |      |
| 7. Birth date of deceased (mo., day, yr.) <u>April 29 1872</u>  |                                      |  |      |
| 6. (c) If alive, give age <u>-</u> years  |                                      |  |      |
| 8. AGE:   | Years                                | Months                                       | Days |
|   | 75                                   | 5  | 23   |
| It less than one day<br>hrs. min.   |                                      |  |      |
| 9. Birthplace <u>Myersville Fred. Co. Md.</u><br>(Town, county, and state)  |                                      |  |      |
| 10. Usual occupation <u>Housewife</u>   |                                      |  |      |
| 11. Industry or business <u>Own Home</u>  |                                      |  |      |
| FATHER  | 12. Name <u>Ezra Beachley</u>        |  |      |
| MOTHER  | 13. Birthplace <u>Myersville Md.</u> |  |      |
|   | 14. Maiden name <u>Caroline Main</u> |  |      |
|   | 15. Birthplace <u>Myersville Md.</u> |  |      |
| 16. Informant <u>Mrs. Ora McFadden</u><br>Address <u>Hagerstown Md.</u>   |                                      |  |      |
| 17. Burial <u>Burial</u> Date thereof <u>10/25/47</u><br>(Burial, cremation, or removal. Which?) (month) (day) (year) |                                      |  |      |
| Cemetery or crematory <u>Dunkard Cemetery</u>   |                                      |  |      |
| Location <u>Beaver creek Md.</u>  |                                      |  |      |
| 18. Funeral director <u>Andrew k. Coffman</u><br>Address <u>Hagerstown Md.</u>  |                                      |  |      |
| 19. <u>Oct. 24, 19 47</u> <u>W. H. Bowers</u><br>(Date rec'd by registrar) Registrar                                  |                                      |  |      |

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 22 1947 at 9.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct 6 1947 to Oct 22 1947  
 and that I last saw her alive on Oct 22 1947

Immediate cause of death

DURATION

Cardio-Renal Disease 2.75 M.

Due to

Due to

Other conditions

Possibly Pneumonia  
Not known  
 (Include pregnancy within 3 months of death)

2 days

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md. Date signed Oct. 24

RECEIVED

OCT 27 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09399  
Reg. Dist. No. 306

## 1. PLACE OF DEATH

County Washington  
 City or town Smithsburg md  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution South Main st.  
 Stay in hospital or inst. (yrs., or mos., or days) -  
 Stay in this community (yrs., or mos., or days) -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Smithsburg md Ward No. -  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. none  
 (If rural give LOCATION)  
 2(c) IF VETERAN, NAME WAR none 220-16-2846

## 3. (a) FULL NAME

Allen S. Geiser

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Leanie Geiser  
 6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

10-17-1879  
 8. AGE: Years Months Days If less than one day  
68 - - - hrs. - min.

9. Birthplace Smithsburg md

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Samuel Geiser13. Birthplace Near Smithsburg14. Maiden name Elizabeth Storer15. Birthplace Near Smithsburg16. Informant Leanie GeiserAddress Smithsburg md17. Burial Date thereof 10-19-1947

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory SmithsburgLocation Smithsburg Wash. Co. md18. Funeral director Geo. B. HowerAddress Smithsburg md19. Oct 18 47 Geo. W. Ferguson

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947 at 7:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 17 1947 and that I last saw him alive on Oct 17 1947

Immediate cause of death

Coronary Thrombosis

DURATION

15 min.Due to Coronary sclerosis 10 yrsDue to -Other conditions -

(Include pregnancy within 8 months of death)

Major findings:

Of operations -Of autopsy -

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE A. G. K. O'Brien

M. D. or other

Address Smithsburg Date signed 10/17/47

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

NEW YORK

RECEIVED  
OCT 20 1947  
BUREAU 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1576

09400

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

# 3 Greenfield Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural Hagerstown Rd. 6  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Greenfield Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Martha Lee Gibson

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1947

## 8. AGE:

Years

Months

Days

If less than one day

414

hrs.

min.

## 9. Birthplace

Hagerstown Washington Rd.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

12. Name James C. Gibson13. Birthplace Arkansas14. Maiden name Mary Ellen Ellis15. Birthplace Washington D.C.16. Informant James C. GibsonAddress Hagerstown Md. R. 617. Burial Date thereof 10/16/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director L. H. ReicherAddress Frankstown Md.19. Oct. 16. 19 47 G. H. Bowers  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 19 47 at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/31 19 47 to 10/15 19 47and that I last saw her alive on 10/15 19 47

Immediate cause of death

MeningitisDue to Spina Bifida

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Bowers M. D. or otherAddress Hagerstown, Md. Date signed 10/16/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 18 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09401

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? Ten days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 320 Linganore Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary S. Gossard

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife James E. Gossard, Sr.  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) March 21, 1867  
 8. AGE: Years 80 Months 6 Days 11 If less than one day ..... hrs. .... min.

9. Birthplace Bakersville, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business .....

FATHER 12. Name Cornelius Ridenour  
 13. Birthplace Hagerstown, Maryland  
 MOTHER 14. Maiden name Anna Rebecca Edmond  
 15. Birthplace Loudan, Virginia

16. Informant Mrs. R. J. Clingan  
 Address Hagerstown, Maryland

17. Burial Date thereof 10-5-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Oct. 3, 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 19 47 at 10:15 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Sept 19 47, to 2 Oct 19 47  
 and that I last saw him alive on 2 Oct 19 47

Immediate cause of death Crown aneurism DURATION 10 days

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Edm. S. Suter M. D. or other  
 Address Hagerstown Date signed Oct 4, 47

RECEIVED

OCT 6 1947

BUREAU 8



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? Pronounced dead on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

Was veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alek Gretzuk

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

1891

## 8. AGE:

Years

Months

Days

If less than one day

56

hrs.

min.

## 9. Birthplace

POLAND

(Town, county, and state)

## 10. Usual occupation

Labor

## 11. Industry or business

Farm

FATHER

## 12. Name

UNKNOWN

## 13. Birthplace

MOTHER

## 14. Maiden name

UNKNOWN

## 15. Birthplace

## 16. Informant

Mrs. Minnie Tucker

## Address

Antietam Furnace, Maryland

## 17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

Oct. 20, 1947  
(month) (day) (year)

## Cemetery or crematory

Fairview Cemetery

## Location

Keedysville, Maryland

## 18. Funeral director

R. I. Earnshaw

## Address

Keedysville, Maryland.

## 19.

Oct. 20, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct/17 19 47 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....  
and that I last saw h.....alive on.....19.....

Immediate cause of death

DURATION

Multiple open fractures

Due to

of skull1 1/2 h

Due to

open fracture of lefttibia & fibula

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

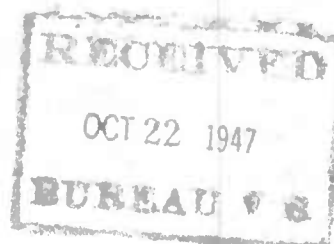
Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct/17/47Where did injury occur? Sharpsburg MD Wash.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Co. Rd RFD 1Means of injury Struck by Auto Injured at work? no23. SIGNATURE S. Robert Wells M. D. orHagerstown, Md. Date signed Oct 18 1947



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

09493

161a

12

### 1. PLACE OF DEATH:

County Washington  
City or town Waguestown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 hours  
Hospital, institution, or street address where death occurred:  
Wash. Co. Hospital  
How long in hospital or institution? 4 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Appleton - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro Md. R. 1  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

Dorlene Delores Griffith

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife Single  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) October - 6 - 1947  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace near Boonsboro Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Albert F. Griffith

13. Birthplace near Sharpsburg Wash. Co. Md.

14. Maiden name Lucille F. Metz

15. Birthplace near Boonsboro Wash. Co. Md.

16. Informant Albert F. Griffith

Address Boonsboro Md.

17. Burial Date thereof Oct. 8, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Best & Son

Address Boonsboro Md.

Oct. 7, 1947 Boonsboro

19. (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1947 to Oct 6, 1947 and that I last saw him alive on Oct. 6, 1947

Immediate cause of death Metastasis of lungs,

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. W. Swan M.D.  
Address Boonsboro Date signed 10/7/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 9 1947

BUFFALO N.Y.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09404 002

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HALEWAY, HAGERSTOWN, MD.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 1/2 yrs

Hospital, institution, or street address where death occurred:  
ROESSNER AVE. EXTENDED

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON  
 City or town HALEWAY, HAGERSTOWN, MD.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ROESSNER AVE. EXTENDED  
 (If rural, give LOCATION)

2.(a) If veteran, name war NON-VET

## 3. (a) FULL NAME

PAUL APPLEMAN GROSSNICKLE

## 3. (b) Social Security Number

577-09-2530

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife JANE ELENORA STERLING6. (c) If alive, give age 33 years7. Birth date of deceased (mo., day, yr.) SEPT. 17, 1906

8. AGE: Years 41 Months 0 Days 20 It less than one day hrs. min.

9. Birthplace MYERSVILLE, FREDERICK, MD.  
 (Town, county, and state)

10. Usual occupation FIREMAN11. Industry or business RAIL ROAD12. Name JOHN M. GROSSNICKLE13. Birthplace MYERSVILLE, MD.14. Maiden name STELLA HARP15. Birthplace MYERSVILLE, MD.16. Informant Mrs. Paul GrossnickleAddress Roessner Ave. Etd.

17. BURIAL Date thereof 10/10/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory GREEN LAWN

Location WILLIAMSPORT, MD.18. Funeral director W. J. NormantAddress Hagerstown, Md.

19. Oct. 9, 47 19 47  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 19 47 at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to 19 47and that I last saw him alive on 19 47

Immediate cause of death

DURATION

Due to acute coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. R. West DEPUTY MEDICAL EXAM.Address Hagerstown, Md. WASH. CO., MD.Date signed 10/9/47

RECEIVED

OCT 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09405

302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... Life  
 Hospital, institution, or street address where death occurred:  
33 East Avenue  
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 33 East Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Martin Harry Gruber

## 3. (b) Social Security Number

None

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married  
 6.(b) Name of husband or wife... Lillian Gruber  
 7. Birth date of deceased (mo., day, yr.)... July 11, 1864  
 8. AGE: Years... 83 Months... 3 Days... 8 If less than one day... hrs. min.

9. Birthplace... Hagerstown, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation... Retired Paper Hanger  
 11. Industry or business...

12. Name... M. Martin Gruber  
 13. Birthplace... Hagerstown, Maryland  
 14. Maiden name... Ann Lavelly  
 15. Birthplace... Hagerstown, Maryland

16. Informant... Mrs. Lillian Zeigler  
 Address... Hagerstown, Maryland  
 17. Burial... Burial Date thereof... 10-22-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Rose Hill Cemetery  
 Location... Hagerstown, Maryland

18. Funeral director... C. M. Suter & Sons  
 Address... Hagerstown, Maryland

19. Oct. 22, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... October 19 19 47 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 19 47, to October 19 19 47, and that I last saw him alive on October 19 19 47.

Immediate cause of death... Cerebral hemorrhage DURATION... 45 min.

Due to... Cerebral Arteriosclerosis indefinite

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... B. B. Bower M. D. or other

Address... 148 W. Washington Street Date signed... Oct 20, 1947

# CERTIFICATE OF DEATH

STATE OF MARYLAND, Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH

## II. PLACE OF DEATH

1. Name of place where death occurred  
 2. Address of place where death occurred  
 3. City or town where death occurred  
 4. State where death occurred

## III. TIME OF DEATH

1. Date of death  
 2. Time of death  
 3. Day of week  
 4. Month of year

**RECEIVED**  
 OCT 24 1947  
**BUREAU**

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, DEPARTMENT OF HEALTH, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER, CITY OR COUNTY, WHERE THE DEATH OCCURRED.

NOT TO BE REPRODUCED FOR PUBLISHING

10-10-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Clearspring--RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
Clearspring R.F.D. #1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Clearspring--RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Clearspring R.F.D. #1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Minnie Hawbaker Guessford

## 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Martin F. Guessford  
 6.(c) If alive, give age 73 years  
 7. Birth date of deceased (mo., day, yr.) December 27, 1871  
 8. AGE: Years 75 Months 9 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Near Clearspring, Wash., Maryland  
 (Town, county, and state)

10. Usual occupation Housewife  
 11. Industry or business At home

12. Name Daniel Hawbaker  
 13. Birthplace Near Greencastle, Penna.

14. Maiden name Susan Socks  
 15. Birthplace Near Greencastle, Penna.

18. Informant Mrs. Helen Reid  
 Address Clearspring, Maryland

17. Burial Date thereof Oct. 13, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Broadfording Cemetery  
 Location Broadfording, Maryland

18. Funeral director Edith V. Leaf  
 Address Williamsport, Maryland

19. October 13 1947 Joseph W. Munn  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/47 19\_\_\_\_ at 7:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/9/46 19\_\_\_\_ to 10/10/47 19\_\_\_\_

and that I last saw him/her alive on 10/9/47 19\_\_\_\_

Immediate cause of death Coronary Occlusion DURATION Day

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joseph W. Munn M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 10/10/47

RECEIVED  
OCT 14 1947  
BUREAU 9 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09497

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? LIFE  
 Hospital, institution, or street address where death occurred:  
WASHINGTON COUNTY HOSPITAL  
 How long in hospital or institution? 5 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County WASHINGTON  
 City or town RURAL - HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. HAGERSTOWN ROUTE #2  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war NON-VET

## 3. (a) FULL NAME

HARLAN THOMAS

## 3. (b) Social Security Number

214-09-0392

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

KATIE V. KREGLO

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

SEPTEMBER 3, 1896

8. AGE:

Years

Months

Days

If less than one day

51118

hrs.

min.

9. Birthplace

HANCOCK, WASHINGTON, MD.  
(Town, county, and state)

10. Usual occupation

WOOD WORKER

11. Industry or business

FURNITURE FACTORY

FATHER

12. Name

GEORGE W. HARR

13. Birthplace

PENNSYLVANIA

MOTHER

14. Maiden name

CARRIE E. MELLOTT

15. Birthplace

HANCOCK, MARYLAND

16. Informant

Thomas M. Harr (Son)

Address

833 Maryland Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

10/24/47  
(month) (day) (year)

Cemetery or crematory

Rest Haven

Location

Hagerstown, Md

18. Funeral director

Walter J. Norment

Address

Hagerstown, Md

19.

(Date rec'd by registrar)

Oct. 22, 47  
Charles Bowser  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947 at 12<sup>30</sup> p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8 1947 to October 21 1947  
and that I last saw him alive on October 21 1947

Immediate cause of death

Carcinoma of large intestine (sigmoid flexure)

DURATION

1 year

Due to

Secondary internal hemorrhage10 minutes

Other conditions

Carcinoma of sigmoid flexure of colon

(Include pregnancy within 3 months of death)

Major findings of operations

no Date of op. Sept 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

None

Injured at work?

23. SIGNATURE

Walter J. Norment

M. D. or other

Address

Hagerstown, MdDate signed 10/22/47

RECEIVED  
OCT 24 1947  
BT READ 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

09498

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?..... 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 411 Jefferson Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Florence E. Hartman

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... White  
 6. (a) Single, married, widowed, or divorced..... Widow  
 6. (b) Name of husband or wife..... Calvin B. Hartman  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... October 21, 1880  
 8. AGE: Years..... 67 Months..... 0 Days..... 9  
 If less than one day..... hrs. .... min.

9. Birthplace..... Hagerstown, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation..... Housework  
 11. Industry or business.....

FATHER  
 12. Name..... Charles H. Metzger  
 13. Birthplace..... Hagerstown, Maryland  
 MOTHER  
 14. Maiden name..... Elizabeth Luft  
 15. Birthplace..... Hagerstown, Maryland

16. Informant..... Edward Hartman  
 Address..... Hagerstown, Maryland  
 17. Burial..... Rest Haven Cemetery  
 (Burial, cremation, or removal. Which?) Date thereof..... 11-1-47  
 (month) (day) (year)  
 Cemetery or crematory..... Hagerstown, Maryland  
 Location.....

18. Funeral director..... C. M. Suter & Sons  
 Address..... Hagerstown, Maryland

19. Oct. 31, 47 Blanch Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 30, 1947 at 2:54 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1947 to October 30, 1947  
 and that I last saw him..... alive on October 30, 1947

Immediate cause of death..... Cerebral hemorrhage with right hemiplegia  
 Due to..... Vascular hypertension and generalized atherosclerosis  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations..... None  
 Date of op.....  
 Autopsy results..... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... None Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... R. J. Gourent M.D. or other  
 Address..... Hagerstown Md Date signed..... Oct 30, 47

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. USUAL RES.

3. FULL NAME

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NOV 3 1947

BUREAU

ORIGINAL NOT BEARER FOR RETURN

FILED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

630

## CERTIFICATE OF DEATH

09499305  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Washington  
City or town Littleton Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Boonsboro Md. 2  
How long in hospital or institution? at Home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Littleton - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro Md. R.2.  
(If rural, give LOCATION)  
2.(a) If veteran, name war No.

### 3. (a) FULL NAME

Annie M. Hought.

### 3. (b) Social Security Number

None.

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Carmie E. Hought  
7. Birth date of deceased (mo., day, yr.) May - 6 - 1870 6.(c) If alive, give age 77 years  
8. AGE: Years 77 Months 5 Days 15 If less than one day  
hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Lewis Jones

13. Birthplace Wash. Co. Md.

14. Maiden name Mary Coffman

15. Birthplace Wash. Co. Md.

16. Informant Carmie E. Hought.

Address Boonsboro Md. R.2.

17. Burial Date thereof Oct. 24 - 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Best & Son

Address Boonsboro Md.

19. Oct. 24. 19 47 John H. Bask  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October - 21 - 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 47 to Oct 21 19 47  
and that I last saw him alive on October 21 19 47

Immediate cause of death Cerebral haemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. J. Best M.D. or other

Address Boonsboro Date signed 10/23/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 27 1947

BUREAU



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09419 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 years  
 Hospital, institution, or street address where death occurred:  
Guilford Avenue Nursing Home  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 546 George St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Keller B. Huyett

3.(b) Social Security Number  
217-10-2569

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Lottie M. Huyett  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) April 21, 1896  
 8. AGE: Years 51 Months 5 Days 17 If less than one day  
 hrs. min.

9. Birthplace Washington Co., Maryland  
 (Town, county, and state)  
 10. Usual occupation Employee D. A. Stickell & sons  
 11. Industry or business  
 12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name  
 15. Birthplace

16. Informant Mrs. Lottie M. Huyett  
 Address 546 George St. Hagerstown, Md.  
 17. Burial Burial Date thereof Oct. 11, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
Hagerstown, Md.  
 Location  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.  
Oct. 14, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 47 at 4:08 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8 August 19 47 to 8 Oct 19 47  
 and that I last saw him alive on 7 Oct 19 47  
 Immediate cause of death  
Carcinoma of lung  
 DURATION  
6 mo  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Eldon G. A. vachhush M. D.  
Hagerstown Md. Date signed 10/10/47  
 Address

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09411 303

1. PLACE OF DEATH  
 County.....*Wash.*  
 City or town.....*Big Spring Rural.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*5 months*  
 Hospital, institution, or street address where death occurred:  
*CR 7. D. - 1.*  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*W. Va.* County.....*Morgan*  
 City or town.....*Berkeley Springs*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME.....*Sidney Ann Irwin*

3. (b) Social Security Number

4. Sex.....*F.* 5. Color or race.....*W.* 6. (a) Single, married, widowed, or divorced.....*Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*April 4, 1864* 6. (c) If alive, give age..... years

8. AGE: Years.....*83* Months.....*6* Days.....*0* If less than one day..... hrs. .... min.

9. Birthplace.....*Phila. Penna.*  
 (Town, county, and state)

10. Usual occupation.....*None*

11. Industry or business

FATHER  
 12. Name.....*James Irwin*  
 13. Birthplace.....*Ireland*  
 MOTHER  
 14. Maiden name.....*Mary J. Mc Birney*  
 15. Birthplace.....*Phila. Pa.*

16. Informant.....*Chas. Shirk*  
 Address.....*Clear Big Spring Md.*

17. Burial, cremation, or removal. Which?.....*Burial* Date interred.....*October 6-1947*  
 (month) (day) (year)

Cemetery or crematory.....*Great Enclosure W.D.*  
 Location.....*" "*

18. Funeral director.....*W.D. Parks*  
 Address.....*Berkeley Springs W.D.*

19. Date rec'd by registrar.....*October 47* Registrar.....*Joseph W. Murray*

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct 4,* 19*47,* at *9 A.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*May 15,* 19*47,* to *Oct 4,* 19*47,*  
 and that I last saw him alive on *Oct 2,* 19*47,*

Immediate cause of death.....*Cerebral Hemorrhage* DURATION.....*6 mo.*

Due to.....*Arterio Sclerosis* 5 yrs.

Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*David P. Brewer M.D.* M. D. or other  
 Address.....*Clear Spring Md.* Date signed.....*10/5/47*

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OCT 8 1947  
BUREAU \* 6

*Murray*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09412

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Suburban  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 weeks  
Hospital, institution, or street address where death occurred:  
Main St.  
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Boonsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro Md. R. 2  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

3. (a) FULL NAME

Franklin Smith Thayer

3. (b) Social Security Number

212-24-2961

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife 6. (c) If alive, give age years

Mary Thayer

7. Birth date of deceased (mo., day, yr.) February - 24 - 1873

8. AGE: Years Months Days If less than one day  
74 7 23 hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Ellis Thayer

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Mary Smith

15. Birthplace Boonsboro Wash. Co. Md.

16. Informant Mrs. Winton Knode

Address Boonsboro Md.

17. Burial Date thereof Oct. 19, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. East & Sons

Address Boonsboro Md.

Oct. 18 - 47 Registrar Charles Powers

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1947, to Oct 17 1947, and that I last saw him alive on October 14 1947

Immediate cause of death Arterio-sclerotic heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adrian Novotny MD. M. D. or other

Address Suburban Md. Date signed 10-17-47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The completed page is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Novotny

RECEIVED

OCT 21 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

460A 09413

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 141 West Washington St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Howard Ityner

3. (b) Social Security Number

214-09-4089

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sue Ityner

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 27, 1880

8. AGE: Years 67 Months 6 Days 10 If less than one day hrs. min.

9. Birthplace Smithsburg Washington Md.  
(Town, county, and state)  
Steward

10. Usual occupation Alsatia Club Inc.

11. Industry or business George Ityner

12. Name Old Forge Md.

13. Birthplace Jenny Bearinger

14. Maiden name Va.

15. Birthplace Mrs Sue Ityner

16. Informant Hagerstown Md.

17. Burial Date thereof 10-9-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Smithsburg Cemetery

Location Smithsburg Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Oct 9, 47 Blackthorn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 47 2:55a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Sept 1947 to 7 Oct 1947  
and that I last saw him alive on 6 Oct 1947

Immediate cause of death Carcinoma oesophagus

DURATION

not known

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Gastrostomy

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J F Lusby M. D. or other

Address 230 N Potomac Date signed 7 Oct 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Yeager

09414

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

31 Wayside Ave.How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 31 Wayside Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war None

## 3. (a) FULL NAME

JOHN KEAGY JACOBS

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Susannah6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) September 6, 18728. AGE: Years 75 Months 1 Days 21 It less than one day hrs. min.9. Birthplace Hagerstown, Washington Co., Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Dr. Henry Jacobs13. Birthplace Chambersburg Pa.14. Maiden name Susanna Keagy15. Birthplace Chambersburg Pa.16. Informant Elverda JacobsAddress Hagerstown Md.17. Burial Date thereof 10/29/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Long Meadows CemeteryLocation Near Paramount Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 29, 1947 Registrar W. Howard Yeager

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947 at 5 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1947 to Oct. 27, 1947and that I last saw him alive on Oct. 26, 1947Immediate cause of death Broncho-pneumoniaDue to Cardio-Renal FailureDue to Myocardial Insufficiency

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. 10-16-47Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

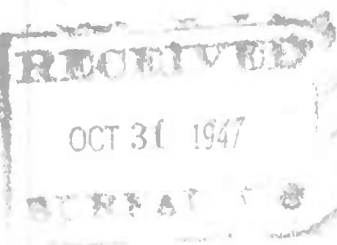
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X X XWhere did injury occur? X X X  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?23. SIGNATURE W. Howard YeagerAddress HagerstownDate signed 10-27-47

M. D. or other



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09415

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 7 1/2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md. RFD  
(If outside city or town limits, write RURAL and give nearest town)Street No. Williamsport, Md RFD #1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. Elvin Roy Kendle

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MarriedB.(b) Name of husband or wife Roda May Sprecker Kendle6.(c) If alive, give age 58 years7. Birth date of  
deceased (mo., day, yr.)Jan. 8 1927 1888

8. AGE:

Years

Months

Days

If less than one day

5994

.....hrs. ....min.

9. Birthplace Franklin Co. Pa.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business FarmFATHER 12. Name John Kendle13. Birthplace Washington Co. Md.MOTHER 14. Maiden name Ida Creilly15. Birthplace Downsville Md.16. Informant John KendleAddress Williamsport Md. RFD17. Burial Date thereof Oct. 16 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosehill CemeteryHagerstown Maryland

Location

18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. Oct. 16. 47 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 10/13/47 19. 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/8/47 19. 10/13/47 19.and that I last saw him alive on 10/13/47 19.

Immediate cause of death

Crowning Eclampsia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. YoungAddress Williamsport Md Date signed 10/15/47

M. D. or other

Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 18 1947

TREAS. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09416

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life Resident  
 Hospital, institution, or street address where death occurred:  
1000 Georgia Avenue  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1000 Georgia Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Harvey Richard Kridler

3. (b) Social Security Number

217-10-3235

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Elda T. Kridler  
 7. Birth date of deceased (mo., day, yr.) June 30, 1886 6. (c) If alive, give age..... years  
 8. AGE: Years 61 Months 3 Days 20 It less than one day  
 ..... hrs. .... min.

9. Birthplace Hagerstown- Wash. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Doorman  
Moose Club  
 11. Industry or business  
 12. Name Harvey R. Kridler  
 13. Birthplace Hagerstown, Md.  
 14. Maiden name Ida V. Kridler  
 15. Birthplace Hagerstown, Md.

16. Informant Mrs. Elda T. Kridler  
 Address 1000 Georgia Ave.- Hagerstown, Md.  
 17. Burial Date thereof Oct. 23, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
Hagerstown, Md.  
 Location  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.  
 19. Oct. 23, 1947 Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1947 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
3 Sept 19 47, to 20 Oct 19 47  
 and that I last saw him alive on 1 Oct 19 47

Immediate cause of death Bilateral Pulmonary tuberculosis DURATION not known

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

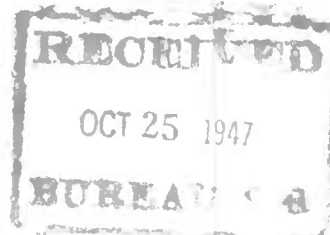
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J F Lusby M. D. or other

Address 230 N Potomac Date signed 21 Oct 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

69517

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Clear Spring RD  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sate Way Nursing Home  
 How long in hospital or institution? 1 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Franklin

City or town Greencastle  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 103 W. Franklin  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

RHODA MAY KRINER

## 3. (b) Social Security Number

None

4. Sex

7

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Charles D. Kriner

6. (c) If alive, give age

65 years

7. Birth date of deceased (mo., day, yr.)

Jan 17, 1888

8. AGE:

Years

Months

Days

If less than one day

59

8

14

hrs.

min.

9. Birthplace

Greencastle Pa  
 (Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Home

MOTHER  
FATHER

12. Name

John W. Kellech

13. Birthplace

Greencastle

14. Maiden name

Susan Cordell

15. Birthplace

Pa.

16. Informant

Chas. W. Kriner

Address

Greencastle Pa

17.

(Burial, cremation, or removal, which?)

Date thereof

Mar 3/47  
 (month) (day) (year)

Cemetary or crematory

Shank's Cemetery

Location

near Greencastle

18. Funeral director

E. E. Minnich

Address

Greencastle Pa

19.

Nov 2  
 (Date rec'd by registrar)

19. 47

Reg. M. L. Fisher  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1947 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/1 1947 to 10/31 1947

and that I last saw him alive on 10/31 1947

Immediate cause of death

Bronchiolitis

DURATION

5 yrs.

Due to

Due to

Other conditions

Congestive heart failure - toxic myocarditis  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Fisher M. D. or other

Address Greencastle Pa. Date signed 11/1/47

RECORDED

DEC 11 1947

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09417

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 yrs. 8 mo. 6 da  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?..... 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 315 Memorial Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Edgar Krouse

## 3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.)..... January 28, 1942 6. (c) If alive, give age..... years  
 8. AGE: Years..... 5 Months..... 8 Days..... 6 It less than one day..... hrs. .... min.

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Oct. 4, 1947 11:00 at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 1947 to Oct 4 1947  
 and that I last saw him alive on Oct 4 1947

Immediate cause of death.....

DURATION

poliomyelitis acute anterior  
 Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results..... not completed Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

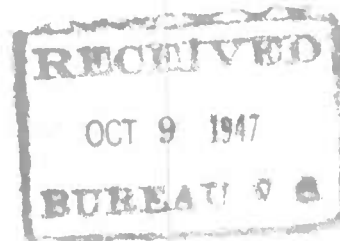
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

9. Birthplace..... Hagerstown, Wash. Md.  
 (Town, county, and state)  
 10. Usual occupation..... School Student  
 11. Industry or business.....  
 12. Name..... Nevin R. Krouse  
 13. Birthplace..... Washington County, Md.  
 14. Maiden name..... Josephine Foltz  
 15. Birthplace..... Washington County, Md.  
 16. Informant..... Mrs. Josephine Krouse  
 Address..... 315 Memorial Blvd., Hagerstown, Md.  
 17. Burial Date thereof..... Oct. 7, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Rose Hill Cemetery  
Hagerstown, Md.  
 Location.....  
 18. Funeral director..... Fred W. Kraiss  
 Address..... Hagerstown, Md.  
 19. Oct. 7, 47 Charles H. Bowers  
 (Date rec'd by registrar) Registrar

23. SIGNATURE..... [Signature] M. D. or other  
 Address..... Hagerstown, Md. Date signed..... 10/6/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 302.

## 1. PLACE OF DEATH

County..... Washington  
 City or town..... Hagerstown Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 yrs.  
 Hospital, institution, or street address where death occurred:

218 East Antietam

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Calif County..... Alameda

City or town..... Oakland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

No

## 3. (a) FULL NAME

James Edward Lloyd

## 3. (b) Social Security Number

None

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... Dora Pitsenogle

7. Birth date of deceased (mo., day, yr.)..... June 18-1866 6.(c) If alive, give age..... years

8. AGE: Years..... 81 Months..... 3 Days..... 21 If less than one day..... hrs..... min.

9. Birthplace..... Jefferson Co W Va.  
 (Town, county, and state)

10. Usual occupation..... Real Estate

## 11. Industry or business

Retired

12. Name..... Dangerfield Lloyd

13. Birthplace..... Jefferson Co W Va

14. Maiden name..... Elizabeth Fleming

15. Birthplace..... Jefferson Co

16. Informant..... Miss Virginia Miller

Address..... 218 E. Antietam Hagerstown Md

17. (Burial, cremation, or removal, which?)..... Buried Date thereof..... Oct 12 47  
 (Month) (Day) (year)

Cemetery or crematorium..... Rosedale

Location..... Martinsburg W Va

18. Funeral director..... Andrew K. Coffman

Address..... Hagerstown Md

19. (Date rec'd by registrar)..... Oct 9 47 Registrar..... Blackbourn

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 9 47 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 45 to Oct 9 47

and that I last saw him alive on Oct 8 47

Immediate cause of death.....

Coronary Vascular Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... X Date of X

Where did injury occur?..... X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

W. Howard Yeager

M. D. or other

Address..... Hagerstown Md Date signed..... 10-9-47

RECEIVED  
OCT 13 1967  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

09419

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

### 1. PLACE OF DEATH:

County Washington  
City or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 43 Years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 119 North Conococheague St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Samuel James Lowman

### 3. (b) Social Security Number

215-01-9873

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Pearl Ellen Lowman  
6.(c) If alive, give age 37 years  
7. Birth date of deceased (mo., day, yr.) April 23, 1900  
8. AGE: Year 47 Month 5 Day 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chewsville, Maryland  
(Town, county, and state)  
10. Usual occupation Sheet Metal Inspector  
11. Industry or business Victor Products Corp.  
12. Name Franklin L. Lowman  
13. Birthplace Leitersburg, Maryland  
14. Maiden name Jennie V. McCauley  
15. Birthplace Whitehall, Maryland

16. Informant Paul E. Lowman  
Address Williamsport, Maryland

17. Burial Burial Date thereof Oct. 11, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Greenlawn, Cemetery  
Location Williamsport, Maryland  
Edith V. Leaf

18. Funeral director Williamsport, Maryland.  
Address

19. Oct-11 19 47 Mrs. E. Lee McElroy  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 47 at 3:25 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Acute coronary occlusion  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results NO  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide NO Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE J. R. Wells DEPUTY MEDICAL EXAM.  
WASH. CO., MD.  
M. D. number \_\_\_\_\_  
Address Hagerstown, Md. Date signed Oct. 9-47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09420

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
 9 W. Franklin Street  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9 W. Franklin Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Carrie E. Lynch

3. (b) Social Security Number  
 None

4. Sex Female 5. Color or race White 6. (c) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Thomas Lynch

7. Birth date of deceased (mo., day, yr.) September 29, 1867

8. AGE: Years 80 Months 0 Days 6 It less than one day hrs. min.

9. Birthplace W. Va.  
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. R. C. Arnsperger

Address 815 Mulberry Ave.- Hagerstown, Md.

17. Burial Date thereof Oct. 8, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct. 8, 1947 Date rec'd by registrar

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1947 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death DURATION

Vascular hypertension 9yr

Due to chr. myocarditis 5 yr

Due to acute ventricular fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wilko DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. other

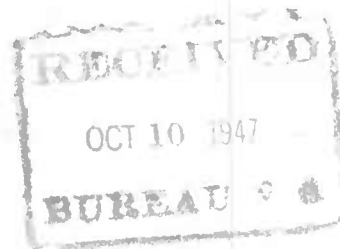
Address Hagerstown, Md. Date signed 10/16/47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years 6 months  
 Hospital, institution, or street address where death occurred:  
Washington Co. Home  
 How long in hospital or institution? 2 years 6 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Wash.  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Etta McCurdy

## 3. (b) Social Security Number

-

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Charles McCurdy  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 15, 1864  
 8. AGE: Year 83 Month 6 Day 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace McConnellsburg, Fulton Co., Pa.  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

**FATHER**  
 12. Name John Suder  
 13. Birthplace Franklin Co., Pa.  
**MOTHER**  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_  
 16. Informant Fred Long  
 Address Hagerstown, Md.  
 17. burial Date thereof 10-9-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Washington Co. Home  
 Location Hagerstown, Md.  
 18. Funeral director Scott F. Minnich & Son  
 Address Hagerstown, Md.  
 19. Oct. 9 1947 East Powers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1947 at 6:00 p.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Oct 8 1947  
 and that I last saw him/her alive on Oct 8 1947.  
 Immediate cause of death \_\_\_\_\_  
Mitral Stenosis  
Aortic Sclerosis  
Hypertension  
Chronic Intestinal  
Nephritis  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

## DURATION

5 yrs.

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Ernest J. Cole MD  
 M. D. or other \_\_\_\_\_  
 Address Hagerstown Md Date signed 10/8/47

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OCT 17 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred 58 Blooms Alley  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 58 Blooms Alley  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Rhodaniel Mc Kinney

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) October 19, 1913  
 8. AGE: Years 33 Months 11 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Wash., Md.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business

FATHER 12. Name John Mc Kinney  
 13. Birthplace Liberty, Md.  
 MOTHER 14. Maiden name Nettie Fisher  
 15. Birthplace Hagerstown, Md.

16. Informant Garfield Mc Kinney  
 Address 58 Blooms Alley  
 17. Burial Date thereof 10/18/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Md.

18. Funeral director William H. Downey  
 Address 291 Frederick St Hagerstown  
Oct. 8. 47 Shirley Bowers  
 19. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947, at 1230 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 6 1947  
 and that I last saw him alive on Oct 1 1947

## Immediate cause of death

Pneumonia

## DURATION

1 mo?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Phyllis J. McKenney

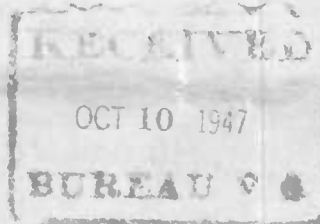
M. D. or other

Address

159 W. Washington St

Date signed

10/7/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

09422

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
245 East Howard St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 245 East Howard St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

PAUL VALENTINE MILLER

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Alice  
 7. Birth date of deceased (mo., day, yr.) August 24 1897  
 6.(c) If alive, give age 49 years  
 8. AGE: Years 50 Months 2 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Shenandoah Page Co. Va.  
 (Town, county, and state)  
 10. Usual occupation Captain of Guards  
 11. Industry or business Md. State Ref. for Males

FATHER 12. Name Perry Miller  
 13. Birthplace Shenandoah Va.  
 MOTHER 14. Maiden name Minnie Valentine  
 15. Birthplace Shenandoah Va.

18. Informant Mrs. Alice Miller  
 Address Hagerstown Md.

17. Burial Date thereof 10/30/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Oct. 30 19 47 Robert P. Conrad  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 27 1947 19 \_\_\_\_\_ at 9.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 19 47 to Oct 27 19 47  
 and that I last saw him alive on Oct 27 19 47

Immediate cause of death Apoplexy  
 DURATION 2 hrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert P. Conrad, M.D. M. D. or otherAddress Hagerstown Md. Date signed 10-28-47

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NOV 1 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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## CERTIFICATE OF DEATH

Reg. Diat. No.

307

### 1. PLACE OF DEATH:

County Washington  
City or town Yamoubeburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Yamoubeburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Charles Mack Myers

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Victoria Luttrell  
7. Birth date of deceased (mo., day, yr.) April 8th 1866 6. (c) If alive, give age 74 years  
8. AGE: Years 81 Months 5 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Retired Farmer  
11. Industry or business Farm  
12. Name Samuel Myers  
13. Birthplace Maryland  
14. Maiden name Margaret Gray  
15. Birthplace Maryland

16. Informant Mrs Victoria Myers  
Address Burial  
17. Burial Date thereof Oct. 7, 1947  
(Burial, cremation, or removal) Which? (month) (day) (year)  
Cemetery or crematory Park Heights  
Location Brownsville Md.  
18. Funeral director C. H. Fisher & Bros  
Address Brownsville Md.  
19. Oct. 6 - 1947 Mrs Catherine Dagenhart  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 47  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 40 to Oct 4 19 47  
and that I last saw him alive on Sept 10 19 47  
Immediate cause of death arteriosclerosis  
DURATION 74  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
Address [Signature] Date signed 10/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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OCT 9 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Parking lot Summit Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Keedysville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Winton Denver Nalley

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Otelia Nalley6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) January 18, 1896

## 8. AGE:

Years 51Months 10Days 3

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Keedysville- Wash. Co., Md.  
(Town, county, and state)10. Usual occupation Trackman11. Industry or business B. an O. R. R.12. Name Joseph Nalley13. Birthplace Tilghmanton, Md.14. Maiden name Martha Piper15. Birthplace Keedysville, Md.16. Informant Mrs. Otelia NalleyAddress Keedysville, Md.17. Burial Date thereof Oct. 24, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran Cemetery  
Bakersville, Md.

Location

18. Funeral director Russel I. Earnshaw

Address

Keedysville, Md.19. Oct. 23, 1947 Chas. H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct/21/47 19 2:20P at \_\_\_\_\_ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

arterio-sclerotic coronary 2moDue to heart diseaseDue to acute coronary occlusion

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

DEPUTY MEDICAL EXAM. WASH. CO., MD.23. SIGNATURE S. Robert Wells M. D. or otherAddress Hagerstown, Md. Date signed Oct. 21-47

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OCT 25 1947  
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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
Washington Co. Hospital  
Length of mother's stay in County.....  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Maryland  
County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 162 Mill St.  
(If RURAL give LOCATION)

3. Name of child Peters  
5. Sex Female | 6. Twin or triplet Single

4. Date of birth Oct. 10 1947 Hour 3.50A M.  
7. No. of weeks pregnancy.....

**FATHER OF CHILD**

8. Full name Theodore Franklin Peters  
9. Color White 10. Age at time of this birth 28 yrs.  
11. Usual occupation Painter & Sander - autos

**MOTHER OF CHILD**

12. Full maiden name Frances Lorraine Metz  
13. Color White 14. Age at time of this birth 22 yrs.  
15. Usual occupation Downsville, Wash. Co. Md.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? Yes During labor?.....

18. Pregnancy, complications of.....

19. Labor: (a) Complications of.....  
(b) Induced? Yes

20. (a) Was there an operation for delivery? No  
(b) State all operations, if any.....  
(Yes or No)

(c) Did child die before operation?.....  
During operation?.....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Malformation - hemicephalus  
(b) Maternal causes .....

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature J. S. Campbell  
(Specify if M. D., midwife, or other)

Address Hagerstown, Md.

23. (a) Burial (b) Date thereof 10/11/47  
(Burial, cremation or removal) (month) (day) (year)  
(c) Cemetery or crematory Bakersville Cem.

25. (a) Oct. 11, 1947 (b) Shash Powers  
(Date rec'd by registrar) (Registrar)

24. (a) Funeral director Andrew K. Coffman  
(b) Address Hagerstown Md.

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per.....

\* See Instruction C on stub.

Infant lived a few minutes.

V. S. A10

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OCT 14 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

## 1. PLACE OF DEATH:

County Washington  
 City or town Sandy Hook  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 80 years  
 Hospital, institution, or street address where death occurred:  
R.F.D., Knoxville, Md.  
 How long in hospital or institution? -----

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Sandy Hook  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D., Knoxville, Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Robert Lee Phillips, Sr.

## 3. (b) Social Security Number

705-12-3626

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Cora Camelia Bagant

7. Birth date of deceased (mo., day, yr.) August 19, 1867  
 6.(c) If alive, give age ----- years

8. AGE: Years 80 Months 2 Days 7 It less than one day ----- hrs. ----- min.

9. Birthplace Sandy Hook, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business B.&O. R. R. Shops12. Name Nimrod N. Phillips13. Birthplace Washington County, Maryland14. Maiden name Jemima J. Guthridge15. Birthplace Fauquier County, Virginia18. Informant Catherine D. McBeeAddress 503 W. Potomac St., Brunswick, Md.17. Burial Date thereof 10/29/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Virts CemeteryLocation Sandy Hook, Maryland18. Funeral director Melvin T. StriderAddress Charles Town, West Virginia19. 10-27-47 C. H. Castle Registrar(Date rec'd by registrar) 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1947 at 3:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20, 1947, to Oct. 26, 1947and that I last saw him Oct. 25, 1947 alive on Oct. 25, 1947Immediate cause of death Carcinoma of liverDURATION ?Due to -----Due to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE W. H. Carpenter M. D. or other -----Address Louettville - Va Date signed 10/27/47

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OCT 30 1947

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

Dr. Ditto

## CERTIFICATE OF DEATH

09426302  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
 City or town Maugansville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Years  
 Hospital, institution, or street address where death occurred:  
Mennonite Home  
 How long in hospital or institution? 4 Years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Mt. Etna Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS SARAH ELIZABETH PITSNOGLE

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Edward  
 7. Birth date of deceased (mo., day, yr.) January 21 1867  
 8. AGE: Years 80 Months 8 Days 21 If less than one day hrs. min.

9. Birthplace Clear Springs Wash. Co. Md.  
 (Town, county, and state)  
Housewife

10. Usual occupation Own Home

11. Industry or business Lancelot Shank  
 12. Name Clear Spring Md.

13. Birthplace Mary Miller  
 14. Maiden name Clear Spring Md.

15. Birthplace Mrs. John B. Keener  
 16. Informant Paramount Md.

17. Burial 10/15/47  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Paradise Cemetery  
 Location near Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown, Maryland

19. Oct. 14, 1947  
 (Date rec'd by registrar) Registrar Chas. Myer

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1947 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 47 to Oct 2 - 47  
 and that I last saw her alive on Oct 4 - 47

Immediate cause of death Chas. Myer

Due to Chas. Myer

Due to Chas. Myer

Other conditions Chas. Myer

(Include pregnancy within 3 months of death)

Major findings of operations Chas. Myer

Date of op. Chas. Myer

Autopsy results Chas. Myer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chas. Myer Date of Chas. Myer

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Chas. Myer

Manner of injury Chas. Myer Injured at work? Chas. Myer

23. SIGNATURE Chas. Myer M. D. or other Chas. Myer

Address Chas. Myer Date signed 10/15/47

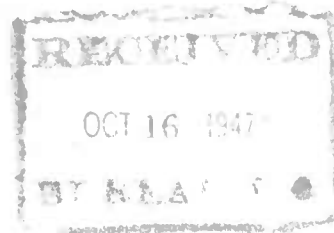
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9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural, Smithsburg Md #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Washington  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Smithsburg Md #2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.  
 6. (b) Name of husband or wife Russell S Pryor  
 6. (c) If alive, give age 50 years  
 7. Birth date of deceased (mo., day, yr.) Aug. 6, 1898  
 8. AGE: Years 49 Months 2 Days 17 If less than one day  
hrs. min.

9. Birthplace Wolfville, Md.  
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name James R Barkman13. Birthplace Frederick Co, Md.14. Maiden name Elizabeth P. Shildknecht15. Birthplace Frederick Co, Md.16. Informant Mr. Russell S PryorAddress Smithsburg Md #217. Burial Date thereof Oct. 26, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Wolfville, Md.18. Funeral director Walter G. GroveAddress Wagonsboro Pa.19. Oct 25 1947 Geo H. Ferguson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 20 1947, to Oct 23 1947and that I last saw him alive on Oct 23 1947Immediate cause of death Coronary Thrombosis DURATION 10 min.Due to Arterio-sclerosisCardio Vascular Hypertension 20 yrsDue to dissectOther conditions L

(Include pregnancy within 8 months of death)

Major findings of operations L

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide L Date ofWhere did injury occur? L (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Y G K Kohler M.D. or otherAddress Smithsburg Md Date signed 10/25/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 5 1947

61 LAU P E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

926

09428

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Middleburg Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war NO

## 3. (a) FULL NAME

Adolph Rastikis

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Rose Rastikis  
 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 5, 1878  
 8. AGE: Years 69 Months 5 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Lithuania  
 (Town, county, and state)

10. Usual occupation Shoemaker

11. Industry or business \_\_\_\_\_

FATHER 12. Name Augustus Rastikis

13. Birthplace Lithuania

MOTHER 14. Maiden name No record

15. Birthplace No record

16. Informant John Rastikis

Address Hagerstown, Md.

17. Burial Date thereof \_\_\_\_\_ (month) (day) (year)  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Melrose Cemetery

Location Brockton, Mass.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Oct. 26, 1947 Registrar Blanch Powers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1947 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Spt 47 to Oct 26 1947  
 and that I last saw him alive on Oct 25 1947

Immediate cause of death Brainia DURATION \_\_\_\_\_

Due to Abund Maxillary Gland

Due to \_\_\_\_\_

Other conditions Myocardial Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

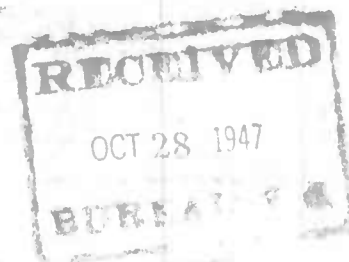
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Blanch Powers M. D. or other \_\_\_\_\_  
 Address Hagerstown, Md. Date signed 10/26/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09429

27

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? LIFE  
 Hospital, institution, or street address where death occurred:  
WASHINGTON COUNTY HOSPITAL  
 How long in hospital or institution? 4 WEEKS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 267 S. POTOMAC ST.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war NON-VET.

## 3. (a) FULL NAME

DANIEL MELVIN REEL

## 3. (b) Social Security Number

NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED  
 6. (b) Name of husband or wife NANNIE BRASHEARS  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) APRIL 17, 1871  
 8. AGE: Years 76 Months 7 Days 5 If less than one day..... hrs. .... min. 27

9. Birthplace SHARPSBURG WASHINGTON, MD.  
 (Town, county, and state)  
 10. Usual occupation RETIRED  
 11. Industry or business HAGERSTOWN CITY EMPLOYEE  
 12. Name SAMUEL REEL  
 13. Birthplace SHARPSBURG, MD.  
 14. Maiden name SARUSSA ANNE PRICE  
 15. Birthplace SHARPSBURG, MD.  
 16. Informant Poscoe Reel (son)  
 Address 267 S. Potomac St.  
 17. Burial Date thereof 10/17/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mountain View Cemetery  
 Location Sharpsburg, Md.  
 18. Funeral director W. J. Harment  
 Address Hagerstown Md.  
 19. Oct. 16, 47 Chas. H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947 at 12 noon  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Oct 14 1947  
 and that I last saw him alive on Oct 14 1947  
 Immediate cause of death Cerebral Hemorrhage  
 DURATION Sept 16-47

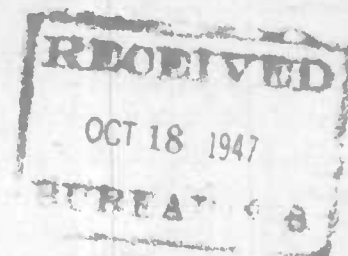
Due to Hypertensive Crisis -  
Essential Disease  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE Henry Novenston M.D.  
 Address Hagerstown Md Date signed 10-15-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Include exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Lagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? six months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Wash  
 City or town Lagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 634 W Franklin  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Ellen Remsburg  
 4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Joseph H Remsburg  
 7. Birth date of deceased (mo., day, yr.) January 10 1889  
 8. AGE: Years 58 Months 8 Days 24 If less than one day  
 6. (c) If alive, give age years

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 10/4/47 19 at 1230 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/29/47 19 to 10/4/47 19  
 and that I last saw him alive on 10/4/47 19  
 Immediate cause of death Coronary Occlusion  
 DURATION 3 Day P.  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

9. Birthplace Washington County  
 (Town, county, and state)  
 1D. Usual occupation Housewife  
 11. Industry or business

12. Name John H Young  
 13. Birthplace Washington County  
 14. Maiden name Henrietta Coffman Young  
 15. Birthplace Washington County  
 16. Informant Ernest Remsburg  
 Address 634 W Franklin St  
 17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 5 1947  
 (month) (day) (year)  
 Cemetery or crematory Mt View Cemetery  
 Location Sharpsburg Wash Co. Md.  
 18. Funeral director William H Darrow  
 Address 291 Frederick St  
 19. Oct 5 1947 Charles H Bowers  
 (Date rec'd by registrar) Registrar

Major findings of operations  
 Date of op  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Willi August, M.D.  
 Address Willi August, M.D. Date signed 10/4/47

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

RECEIVED

OCT 7 1947

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

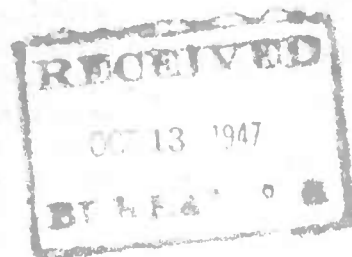
## CERTIFICATE OF DEATH

Reg. Dist. No. 302

09432

20

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH:</b><br>County..... <u>Washington</u><br>City or town..... <u>Hagerstown</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death?..... <u>35 years</u><br>Hospital, institution, or street address where death occurred:<br><u>Washington County Hospital</u><br>How long in hospital or institution?..... <u>1 day</u> |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(For newborn infants give residence of mother)<br>State..... <u>Maryland</u> County..... <u>Washington</u><br>City or town..... <u>Hagerstown</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No..... <u>417 N. Locust St</u><br>(If rural, give LOCATION)<br>2.(a) If veteran, name war.....  |  |  |  |
| <b>3.(a) FULL NAME</b> <u>Gerell Ridley</u>   |  |  |  | <b>3.(b) Social Security Number</b><br><u>213-10-6840</u>  |  |  |  |
| <b>4. Sex</b> <u>Male</u>   |  |  |  | <b>5. Color or race</b> <u>White</u>   |  |  |  |
| <b>6.(a) Single, married, widowed, or divorced</b> <u>Married</u>   |  |  |  | <b>6.(b) Name of husband or wife</b> <u>Margaret Dougan Ridley</u>   |  |  |  |
| <b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 10, 1872</u>  |  |  |  | <b>6.(c) If alive, give age</b> ..... years  |  |  |  |
| <b>8. AGE:</b> Years <u>75</u> Months <u>4</u> Days <u>27</u> (If less than one day hrs. min.   |  |  |  | <b>6.(c) If alive, give age</b> ..... years  |  |  |  |
| <b>9. Birthplace</b> <u>Phelps, New York</u><br>(Town, county, and state)   |  |  |  | <b>10. Usual occupation</b> <u>Steam Fitter</u>  |  |  |  |
| <b>11. Industry or business</b> <u>N. AM. Cement Co.</u>  |  |  |  | <b>12. Name</b> <u>George Ridley</u>   |  |  |  |
| <b>13. Birthplace</b> <u>New York</u>   |  |  |  | <b>14. Maiden name</b> <u>Emma</u>   |  |  |  |
| <b>15. Birthplace</b> <u>New York</u>   |  |  |  | <b>16. Informant</b> <u>Mrs. Margaret Ridley</u>   |  |  |  |
| <b>Address</b> <u>417 N. Locust St- Hagerstown, Md</u>  |  |  |  | <b>17. Burial</b> <u>Rose Hill Cemetery</u><br>(Burial, cremation, or removal, Which?) Date thereof <u>Oct. 10-47</u><br>(month) (day) (year)<br>Cemetery or crematory.....<br>Location..... <u>Hagerstown, Md.</u>  |  |  |  |
| <b>18. Funeral director</b> <u>Fred W. Kraiss</u><br>Address..... <u>Hagerstown, Md.</u>  |  |  |  | <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b><br><u>December 1943</u> to <u>Oct. 7, 1947</u><br>and that I last saw him alive on <u>October 7, 1947</u><br>Immediate cause of death.....<br><u>Carcinomatosis, which originated in month 15 years ago.</u><br>Due to.....<br>Due to.....<br>Other conditions.....<br>(Include pregnancy within 3 months of death)<br>Major findings of operations..... <u>Carcinoma of month 15 years ago.</u><br>Date of op.....<br>Autopsy results.....<br>PHYSICIAN: Please underline the cause to which death should be charged statistically.<br><b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:<br>Accident, suicide, or homicide..... Date of.....<br>Where did injury occur?..... (City or town) (County) (State)<br>Injured at home, farm, industry, public place (where?)<br>Means of injury..... Injured at work? |  |  |  |
| <b>19. (Date rec'd by registrar)</b> <u>Oct. 10. 47</u> <u>W. Bowers</u><br>Registrar   |  |  |  | <b>23. SIGNATURE</b> <u>Ra Bowers</u><br>Address..... <u>Hagerstown</u> Date signed.....   |  |  |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

09431

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Security Road, R.F.D. #5  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Unnamed Baby (Rohrer)

## 3. (b) Social Security Number

|  |                                  |   |
|--|----------------------------------|---|
| 4. Sex<br><u>Male</u>  | 5. Color or race<br><u>White</u> | 6. (a) Single, married, widowed, or divorced<br><u>Single</u> |
| 6. (b) Name of husband or wife                                   |                                  |   |
| 6. (c) If alive, give age years                                  |                                  |   |
| 7. Birth date of deceased (mo., day, yr.) <u>October 3, 1947</u> |                                  |   |
| 8. AGE: Years<br><u>0</u>  | Months<br><u>0</u>               | Days<br><u>4</u><br>hrs. min.                                 |

9. Birthplace Hagerstown, Maryland  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
 12. Name Howell Rohrer  
 13. Birthplace Hagerstown, Maryland  
 MOTHER  
 14. Maiden name Ruth Dayhoff  
 15. Birthplace Hagerstown, Maryland

16. Informant Howell RohrerAddress Security Road, R.F.D. #5

17. Burial Date thereof 10-7-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland

19. Oct. 7, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 47 at 4:52 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 47 to Oct 7 19 47  
 and that I last saw him alive on Oct 6 19 47

Immediate cause of death Cerebral hemorrhage DURATION 4 days

Due to Unknown cause

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Layman, M.D. M. D. or other

Address 100 Professional Bldg, Bldg  
Hagerstown, Md. Date signed Oct 7 1947

MARYLAND STATE DEPARTMENT OF HEALTH

1111 N. E. Street, Baltimore, Md.

CERTIFICATE OF DEATH

A. J. JONES

RECEIVED  
OCT 9 1947  
BUREAU  
RECEIVED  
OCT 9 1947  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Dr. Kohler

09433

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 Months  
 Hospital, institution, or street address where death occurred:  
Main St.  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Main Street  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

TRENTON CARRINGTON SCHROYER

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Lola E.

7. Birth date of deceased (mo., day, yr.) November 21, 1864  
 6. (c) If alive, give age --- years

8. AGE: Years 82 Months 11 Days 8 If less than one day  
 .....hrs. ....min.

9. Birthplace Wolfsville, Fredrick Co., Md.  
 (Town, county, and state)

10. Usual occupation Merchant11. Industry or business Retired12. Name Lawson Schroyer13. Birthplace Wolfsville Md.14. Maiden name Wilhemina Witmer15. Birthplace Wolfsville, Md

16. Informant Edwin C. Schroyer  
 Address Smithsburg Md.

17. Burial Date thereof 11/2/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran CemeteryLocation Wolfsville Fredrick Co., Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

18. Oct 31 18 47 Geo. W. Ferguson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 19 47 at 8:45P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 14 19 47, to Oct 29 19 47  
 and that I last saw him alive on Oct 29 19 47

Immediate cause of death

General Thrombosis DURATION 3 days

Due to Arterio Sclerosis 10 yrs.

Due to Pharyngeal Prostate 4 yrs

Other conditions Chronic Nephritis 8 yrs

(Include pregnancy within 3 months of death)

Major findings of operation ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE G. G. Kohler M. D. or otherAddress Smithsburg Date signed 10/31/47

RECEIVED

NOV 5 1947

151 240 9 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the correct age in the correct age space. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

09434

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH:</b><br>County..... <u>Washington</u><br>City or town..... <u>Hagerstown</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death?..... <u>Life</u><br>Hospital, institution, or street address where death occurred:<br><u>Washington County Hospital</u><br>How long in hospital or institution?..... <u>6 hours</u> |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(For newborn infants give residence of mother)<br>State..... <u>Maryland</u> County..... <u>Washington</u><br>City or town..... <u>Hagerstown</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No..... <u>Nottingham Road</u><br>(If rural, give LOCATION)<br>2.(a) If veteran, name war..... |  |
|---|--|--|--|

|  |   |
|--|---|
| <b>3. (a) FULL NAME</b><br><u>Ruth May Settles</u> | <b>3. (b) Social Security Number</b><br><u>None</u> |
|--|---|

|  |                                  |   |
|--|----------------------------------|---|
| 4. Sex<br><u>Female</u>  | 5. Color or race<br><u>White</u> | 6.(a) Single, married, widowed, or divorced<br><u>Married</u> |
| 6.(b) Name of husband or wife..... <u>Charles Settles</u>            |                                  |   |
| 7. Birth date of deceased (mo., day, yr.)<br><u>December 8, 1915</u> |                                  |   |
| 6.(c) If alive, give age..... years                                  |                                  |   |
| 8. AGE:  | Years<br><u>31</u>               | Months<br><u>10</u>   |
|  | Days<br><u>19</u>                | If less than one day<br>..... hrs. .... min.                  |

|   |
|---|
| 9. Birthplace..... <u>Hagerstown Washington Co., Md.</u><br>(Town, county, and state) |
| 10. Usual occupation..... <u>Home Duties</u>  |

|  |
|--|
| 11. Industry or business                     |
| 12. Name..... <u>Clayton Diffenderfer</u>    |
| 13. Birthplace..... <u>Clear Spring, Md.</u> |
| 14. Maiden name..... <u>Grace Billman</u>    |
| 15. Birthplace..... <u>Shamokin, Pa.</u>     |

|  |
|--|
| 16. Informant..... <u>Mrs. Grace Dundus</u>          |
| Address..... <u>Nottingham Road- Hagerstown, Md.</u> |

|  |  |
|--|--|
| 17. <u>Burial</u><br>(Burial, cremation, or removal, Which?) | Date thereof..... <u>Oct. 30, 1947</u><br>(month) (day) (year) |
| Cemetery or crematory..... <u>Rose Hill Cemetery</u>         |  |
| Location..... <u>Hagerstown, Md.</u>                         |  |

|   |
|---|
| 18. Funeral director..... <u>Fred W. Kraiss</u> |
| Address..... <u>Hagerstown, Md.</u>             |

|   |                                  |
|---|----------------------------------|
| 19. <u>Oct. 30, 1947</u><br>(Date rec'd by registrar) | <u>Black Bowers</u><br>Registrar |
|---|----------------------------------|

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 27, 1947 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27, 1947 to Oct 27, 1947; and that I last saw him/her alive on Oct 27, 1947.

Immediate cause of death..... Cerebral Hemorrhage  
 DURATION..... 1 day

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... [Signature] M.D. or other  
 Address..... [Signature] Date signed.....

RECEIVED  
NOV 1 1947  
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

09435

37

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years  
 Hospital, institution, or street address where death occurred:  
802 Marshall St.

How long in hospital or institution? ---2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 802 Marshall St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

GEORGE EMERSON SHANER

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife ---

7. Birth date of deceased (mo., day, yr.) September 22, 1908  
 6. (c) If alive, give age --- years

8. AGE: Years 39 Months 0 Days 28 If less than one day --- hrs. --- min.

9. Birthplace Westminister, Carrol Co. Md.  
 (Town, county, and state)

10. Usual occupation Bethlehem Steel Co.11. Industry or business Moulder12. Name George F. Shaner13. Birthplace Westminister Md.14. Maiden name Nellie Taylor15. Birthplace Westminister Md.

16. Informant Mrs. Nellie T. Miller  
 Address Hagerstown Md.

17. Burial Date thereof 10/22/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffranAddress Hagerstown Md.

19. Oct. 21, 1947  
 (Date rec'd by registrar) Registrar G. H. Bowers

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 20, 19 47, at 1.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1-47 to Oct 20, 47  
 and that I last saw him alive on Oct 20-47 19 47

Immediate cause of death

DURATION

Encephalitis Chronic 2 yrs  
 Due to ---

Due to ---

Other conditions Bronchial pneumonia 48 hrs.  
11/19/47  
 (Include pregnancy within 3 months of death) 23.

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please endorse the cause to which death should be charged statistically.

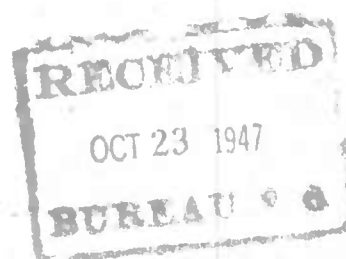
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---

23. SIGNATURE [Signature] M. D. or other ---  
 Address Hagerstown Md. Date signed 10/21/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09437

14

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 35 years  
 Hospital, institution, or street address where death occurred:  
650 Oak Hill Avenue  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 650 Oak Hill Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

George E. Slaybaugh

## 3. (b) Social Security Number

232-01-8412

|  |                                  |   |
|--|----------------------------------|---|
| 4. Sex<br><u>Male</u>  | 5. Color or race<br><u>White</u> | 6.(a) Single, married, widowed, or divorced<br><u>Married</u> |
| 6.(b) Name of husband or wife..... <u>Eva M. Slaybaugh</u>         |                                  |   |
| 7. Birth date of deceased (mo., day, yr.) <u>September 6, 1880</u> |                                  |   |
| 6.(c) If alive, give age..... <u>56</u> years                      |                                  |   |
| 8. AGE:  | Years                            | Months  |
|  | <u>67</u>                        | <u>1</u>  |
|  |                                  | Days  |
|  |                                  | <u>1</u>  |
|  |                                  | If less than one day  |
|  |                                  | .....hrs. ....min.  |

9. Birthplace..... New Kingston, Pa.  
 (Town, county, and state)  
 10. Usual occupation..... Certified Public Accountant  
 11. Industry or business..... Own Business

|        |  |
|--------|--|
| FATHER | 12. Name..... <u>George H. Slaybaugh</u>     |
|        | 13. Birthplace..... <u>Adams Co. Pa.</u>     |
| MOTHER | 14. Maiden name..... <u>Annie L. Law</u>     |
|        | 15. Birthplace..... <u>Shippensburg, Pa.</u> |

16. Informant..... Mrs. Geo. E. Slaybaugh  
 Address..... Hagerstown, Maryland  
 17. Burial..... Date thereof..... 10-9-47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Rest Haven Cemetery  
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons  
 Address..... Hagerstown, Maryland

19. Oct. 8, 47.....  
 (Date rec'd by registrar) Registrar..... E. Kraft Bowers

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 7..... 47 at 7:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 16 19 41 to Oct 7 19 47  
 and that I last saw him alive on Oct 6 19 47

Immediate cause of death.....  
Coronary Thrombosis DURATION 10/7/47

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... H. L. Porterfield M.D.  
 Address..... 136 W Washington Date signed..... 10/7/47

CERTIFICATE OF DEATH

1. Usual Residence

2. Place of Death

RECEIVED  
OCT 10 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Beachley

09438

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Hour  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 Hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R. F. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Beards Church Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

ALBERT R. SMITH

## 3. (b) Social Security Number

220-07-6377

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife --  
 7. Birth date of deceased (mo., day, yr.) January 13 1890  
 8. AGE: Year 57 Months 9 Days 10 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Md.  
 (Town, county, and state)

10. Usual occupation Cook  
 11. Industry or business Restaurant

12. Name No Record  
 13. Birthplace No Record  
 14. Maiden name No Record  
 15. Birthplace No Record

16. Informant Hagerstown Police Dept.  
 Address Hagerstown Md.

17. Burial Burial Date thereof 10/29/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Oct. 29, 47 Registrar Beards Church Road  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947 19... at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death Crushing Injury to Pelvis DURATION 1 hour

Due to Pelvis  
 Due to Pelvis  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Acc. Date of 10/23/47  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Barney  
 Means of injury Runaway horse & team ran over him. Injured at work?

23. SIGNATURE Dr. Beachley M.D. Beards Church Road  
 Address Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09439

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Enroute to Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town Rural Middletown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Esta Jane Smith

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife John Smith

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

69 8 27 hrs. min.9. Birthplace Myersville Fred. Co., Md.  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name John P. Flook13. Birthplace Middletown, Md.14. Maiden name Rebecca Ann Derr15. Birthplace Middletown, Md.16. Informant Frank SmithAddress Middletown, Md.17. Burial Date thereof 10-21-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Middletown, Md.18. Funeral director Bladhill Co.Address Middletown, Md.19. Oct. 20, 1947 Blas H. Bower  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct/18 47 6:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death \_\_\_\_\_

DURATION

acute coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

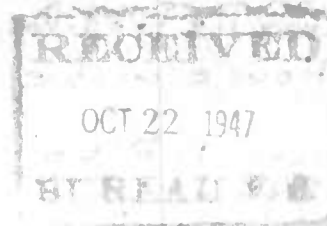
23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
M. D. or \_\_\_\_\_ WASH. CO., MD.Address Hagerstown, Md. Date signed Oct. 19/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Kohler

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

922

09440

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Near Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 34 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Otha Ray Smith

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 8. (b) Name of husband or wife Flora Rubin  
 8. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Feb 3 1881  
 8. AGE: Years 66 Months 8 Days 11 It less than one day ..... hrs. .... min.

9. Birthplace Fredrick Co Md  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John Smith13. Birthplace Fredrick Co Md14. Maiden name Maria Mangano15. Birthplace Washington Co Md18. Informant Mrs Melvin JonesAddress Hagerstown Md17. Burial Date thereof 10 17 1947

(Burial) cremation, or removal. Which? (month) (day) (year)

Cemetery or crematory Smithsburg CemeteryLocation Smithsburg Md18. Funeral director Walter H. GroveAddress Waynesboro Virginia19. Oct 15 1947 19 47 Geo H. Ferguson

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Washington  
 City or town Hagerstown #5  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 14 1947 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 20 1947 to Oct 14 1947and that I last saw him/her live on Oct 14 1947Immediate cause of death Pulmonary embolism DURATION 10 daysdue toEndocarditis & uric aciddue toflexion, one at a time 3 wksHeartOther conditions Aspergillus Aspergillus& emphysema

(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

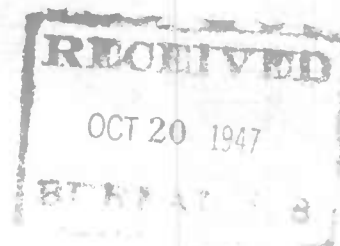
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. Kohler M. D. or otherAddress Smithsburg Date signed 10/15/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

03441

306

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County WashingtonCity or town Leavetown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? —Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Leavetown  
(If outside city or town limits, write RURAL and give nearest town)Street No. none  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

William V. Smith

## 3. (b) Social Security Number

no4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jennie Smith6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) 8-2-18628. AGE: Years 84 Months 10 Days 1 If less than one day — hrs. — min.9. Birthplace near Hallsville, Fred Co md  
(Town, county, and state)10. Usual occupation Farming11. Industry or business —12. Name Joseph Smith13. Birthplace near Hallsville, Fred Co md14. Maiden name Miriam Ann Farahit15. Birthplace near Hallsville, Fred Co md16. Informant Jennie SmithAddress Leavetown md17. Burial (Burial, cremation, or removal. Write!) Smithsburg CemeteryDate thereof 10-5-1947  
(month) (day) (year)Cemetery or crematorium Smithsburg mdLocation Leavetown md18. Funeral director Leavetown mdAddress Leavetown md19. Oct 4 1947 Per W Ferguson  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1947 at 4A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 3 1947and that I last saw him alive on Oct 3 1947Immediate cause of death General Hemorrhage DURATION 18 daysDue to Arterio sclerosis 10 yrsDue to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE E. G. F. Oiler M. D. or otherAddress Leavetown md Date signed 10/3/47

RECEIVED

OCT 8 1947

BUREAU 9 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Zimmerman

09442

Reg. Dist. No. 302

## I. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 Years  
 Hospital, institution, or street address where death occurred:  
9 Roessner Ave  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9 Roessner Ave  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. May M. Snyder

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Robert B. Snyder Sr.  
 7. Birth date of deceased (mo., day, yr.) October 1 1862  
 6.(c) If alive, give age 80 years  
 8. AGE: Years 85 Months 0 Days 1 If less than one day hrs. min.

9. Birthplace Alpharetta Milton Co. Georgia  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home

FATHER 12. Name James G. Bowen  
 13. Birthplace Anderson So. Carolina  
 MOTHER 14. Maiden name Frances Richards  
 15. Birthplace Herndon Va.

18. Informant Robert B. Snyder Sr.  
 Address Hagerstown Md.

17. Burial Date thereof 10/4/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md

19. Oct. 4. 19 47 Beach Towers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947 19 47 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 47 to Oct. 2 19 47  
 and that I last saw him alive on Oct. 2 19 47

Immediate cause of death Cerebral embolism DURATION 15 min.

Due to myocarditis Chronic 1 year

Due to Cerebral embolism 6 mos.

Other conditions Cerebral embolism

(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results ---  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide --- Date of ---  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---  
 Means of injury --- Injured at work? ---

23. SIGNATURE William Zimmerman M. D. or other ---  
 Address William Zimmerman Md Date signed 10/3/47

RECEIVED

OCT 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

61

09443

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
 City or town Beaver Creek - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Hagerstown Md. R. 1  
 How long in hospital or institution? at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Beaver Creek - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Md. R. 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No.

## 3. (a) FULL NAME

William Frisby Suman

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nancy E. Suman

7. Birth date of deceased (mo., day, yr.) January - 31 - 1872 6. (c) If alive, give age 75 years

8. AGE: Years 75 Months 8 Days 21 If less than one day hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.  
 (Town, county, and state)

10. Usual occupation Farmer  
'Retired'

11. Industry or business

12. Name John Suman

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Elizabeth Nyman

15. Birthplace Boonsboro Wash. Co. Md.

16. Informant Mrs. Nancy E. Suman

Address Hagerstown Md. R. 1

17. Burial Date thereof Oct. 25, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of the Brethren Cemetery

Location Beaver Creek Md.

18. Funeral director Chas. J. Best & Son

Address Boonsboro Md.

19. Oct. 24, 1947 John H. Best  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October - 22 - 1947 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1947 to Oct 22, 1947  
 and that I last saw him alive on Sept 22, 1947

Immediate cause of death Pulmonary Edema DURATION 12 hrs

Due to Chronic Endocarditis 20 yrs

Ischemic Heart 3 mos

Coronary Atherosclerosis 10 yrs

Other conditions Generalized Arterio-Sclerosis 10 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations L Date of op. \_\_\_\_\_

Autopsy results L  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide L Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. G. K. Opler M. D. or other \_\_\_\_\_

Address Smithsburg Date signed 10/23/47



RECEIVED

OCT 27 1947

BUREAU



PLEASE WRITE PLAINLY, WITHOUT UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09444

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 214 Summit Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Maude Grace Ward

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife John William Ward  
 7. Birth date of deceased (mo., day, yr.) January 23, 1883  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 64 Months 8 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington County, Md.  
 (Town, county, and state)  
 10. Usual occupation Home Duties  
 11. Industry or business

12. Name Samuel Rogers-  
 13. Birthplace Staunton, Va.  
 14. Maiden name Elizabeth Pryor  
 15. Birthplace Washington County, Md.

16. Informant Mrs. Virginia Knode  
 Address W. Antietam St.- Hagerstown,

17. Burial Date thereof Oct. 16-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland.

19. Oct. 16. 47 Registrar Charles Howard  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1947 2:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to Oct. 14, 1947  
 and that I last saw him alive on October 13, 1947  
 Immediate cause of death

Actinomyces 8 mo.  
Infection by Actinomyces  
Secondary anemia  
 (Include pregnancy within 3 months of death)  
 Major findings of operations No operation  
 Date of op. \_\_\_\_\_  
 Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Ra. Brew M. D. 10/15/47  
 Address Hagerstown Md. Date signed

RECEIVED

OCT 18 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09445

Reg. Dist. No.

306

## 1. PLACE OF DEATH

County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Theodore Samuel Hastler

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Sylvia M. Flaugher6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) May 11, 18888. AGE: Years 59 Months 4 Days 22 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sabellville Md.  
(Town, county, and state)10. Usual occupation Post master at11. Industry or business Cascade12. Name Theodore A. Hastler13. Birthplace Thurmont Md.14. Maiden name Alma S. Royce15. Birthplace Cascade, Md.16. Informant T. Allen HastlerAddress Penacola Fla.17. Burial Date thereof 10/5/47  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory BethelLocation Cascade, Md.18. Funeral director Walter Z. StoneAddress 77 S. Church St. Waynesburg Pa.19. Oct 4 1947 Geo. W. Ferguson  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 October 1947 at 7:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 July 1947 to 3 October 1947 and that I last saw him alive on 2 October 1947Immediate cause of death Cancer of the stomachDue to Cancer of the stomachDue to Cancer of the stomach

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert A. Kierlin, M.D.Address Blue Ridge Summit Pa. D. or other \_\_\_\_\_Date signed 3 Oct. 1947

RECEIVED

OCT 8 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09446

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? at home

## 3. (a) FULL NAME

Mary Ellen Haugh  
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife James Haugh  
 7. Birth date of deceased (mo., day, yr.) March 24, 1876 8. (c) If alive, give age 21 years

8. AGE: Years 71 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace Funkstown  
 (Town, county, and state)

10. Usual occupation Housewife  
 11. Industry or business Housewife

12. Name John F. Haugh  
 13. Birthplace Unknown

14. Maiden name Margie Hughes  
 15. Birthplace Unknown

16. Informant James Haugh  
 Address Funkstown Md

17. Burial Date thereof 10-20-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Funkstown Cemetery  
 Location Funkstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Oct. 20, 1947 Blanch Flowers  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wash  
 City or town Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.   
 (If rural, give LOCATION)

2. (a) If veteran, name war 

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31, 1946 to Oct 17, 1947

and that last saw him alive on October 17, 1947

Immediate cause of death Systolic Cardiac  
vascular disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Sidney Novenstein MD M. D. or other

Address Funkstown Md Date signed 10-18-47

121

CERTIFICATE OF DEATH

STATE OF NEW YORK

PLACE OF BIRTH

RECEIVED  
OCT 22 1947  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:  
313 S. Cannon Ave.

How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 - S. Cannon Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war Vietnam & World War 2 -

### 3. (a) FULL NAME

Herschel Owen Weaver

### 3. (b) Social Security Number

214-09-5523

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Married

#### 6. (b) Name of husband or wife

Mary C. Weaver

#### 7. Birth date of deceased (mo., day, yr.)

April - 12 - 1903

#### 6. (c) If alive, give age

years

#### 8. AGE:

Years

Months

Days

If less than one day

44

6

12

hrs.

min.

#### 9. Birthplace

Keedysville Wash. Co. Md.  
(Town, county, and state)

#### 10. Usual occupation

Edge Trimmer

#### 11. Industry or business

Carlisle Shoe Co.

FATHER  
MOTHER

#### 12. Name

W. Clayton Weaver

#### 13. Birthplace

Clearspring Wash. Co. Md.

#### 14. Maiden name

Core E. Long

#### 15. Birthplace

Middletown Fred. Co. Md.

#### 16. Informant

Mrs. Mary C. Weaver

#### Address

313 S. Cannon Ave. Hagerstown Md.

#### 17.

Burial  
(Burial, cremation, or removal. Which?)

Oct 27 1947  
Date thereof (month) (day) (year)

#### Cemetery or crematory

Fairview Cemetery

#### Location

Keedysville Md.

#### 18. Funeral director

Wm D. Bart & Sons

#### Address

Boonsboro Md

#### 19.

Oct. 27. 1947  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 12 1947 to Oct 24 1947  
and that I last saw him alive on October 24 1947

Immediate cause of death

Coronary Thrombosis (Oct 2-4)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md Date signed 10-25-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 29 1947

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09448

Reg. Dist. No. 300

## 1. PLACE OF DEATH

County..... Washington  
 City or town..... Sharpsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 years  
 Hospital, institution, or street address where death occurred:  
Main St.  
 How long in hospital or institution?..... at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Sharpsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Main St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... No.

## 3. (a) FULL NAME

Henry Barton Whittington

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ella Whittington

## 7. Birth date of deceased (mo., day, yr.)

September - 22 - 1879

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

68017

hrs.

min.

## 9. Birthplace

Hume Virginia  
(Town, county, and state)

## 10. Usual occupation

Retired Farmer

## 11. Industry or business

FATHER

## 12. Name

Robert Whittington

## 13. Birthplace

Virginia

MOTHER

## 14. Maiden name

Helen Payne

## 15. Birthplace

Virginia

## 16. Informant

Mrs. Ella Whittington

## Address

Sharpsburg Md.

## 17.

Burial  
(Burial, cremation, or removal, Which?)

## Date thereof

Oct. 11, 1947  
(month) (day) (year)

## Cemetery or crematory

St. Marks Cemetery

## Location

Cappas Md.

## 18. Funeral director

Wm. D. - Best & Sons

## Address

Brownsville Md.

## 19.

10-11  
(Date rec'd by registrar)

19

47E. J. Boyers

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 9 1947 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1947 to Oct 9 1947  
and that I last saw him alive on Oct 9 1947

## Immediate cause of death

Epilepsy

## DURATION

12 hours

## Due to

Cardio-vascular  
renal disease

## Due to

2nd +

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

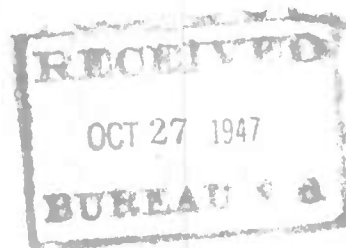
## 23. SIGNATURE

Walter H. Shealy MD

M. D. or other

Address

Sharpsburg, Md.Date signed 10/9/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932

09449

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
534 Brown Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 534 Brown Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Jacob Walter Widmyer

## 3. (b) Social Security Number

214-09-9879

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Ruth C. Widmyer  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 8, 1874  
 8. AGE: 63 Years 2 Months 20 Days It less than one day  
 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington County, Md.  
 (Town, county, and state)  
 10. Usual occupation Carpenter  
 11. Industry or business  
 12. Name Thomas W. Widmyer  
 13. Birthplace Washington County, Md.  
 14. Maiden name Margaret R. Murray  
 15. Birthplace Washington County, Md.

16. Informant Miss Helen Widmyer  
 Address 534 Brown Avenue- Hagerstown,  
Burial Date thereof Oct. 30, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Md.  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.  
Oct. 31, 1947 Charles H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

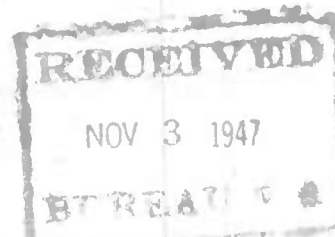
20. DATE OF DEATH October 28, 1947 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/46 to 10/28/47  
 and that I last saw him live on 10/27/47

Immediate cause of death Congestive heart failure DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Chronic Myocarditis 2 yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
Md.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Paul Young MD M. D. or other \_\_\_\_\_  
Hagerstown, Md Date signed 10/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1318

09450

Reg. Dist. No.

305

## 1. PLACE OF DEATH:

County Washington  
 City or town Boonsboro  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Boonsboro  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Davis Wilhide

## 3. (b) Social Security Number

None

|                       |                                  |  |
|-----------------------|----------------------------------|--|
| 4. Sex<br><b>Male</b> | 5. Color or race<br><b>White</b> | 6. (a) Single, married, widowed, or divorced<br><b>Married</b> |
|-----------------------|----------------------------------|--|

6. (b) Name of husband or wife Alice (Knadler) Wilhide  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1866

|         |           |           |           |                       |
|---------|-----------|-----------|-----------|-----------------------|
| 8. AGE: | Years     | Months    | Days      | If less than one day  |
|         | <b>80</b> | <b>11</b> | <b>23</b> | _____ hrs. _____ min. |

9. Birthplace Middle town-Frederick-Md  
(Town, county, and state)10. Usual occupation Retired Merchant

11. Industry or business \_\_\_\_\_

|        |                 |                             |
|--------|-----------------|-----------------------------|
| MOTHER | 12. Name        | <u>Jacob Wilhide</u>        |
|        | 13. Birthplace  | <u>Frederick County--Md</u> |
| FATHER | 14. Maiden name | <u>Amie Fox</u>             |
|        | 15. Birthplace  | <u>Frederick County--Md</u> |

16. Informant Mrs. Alice Wilhide  
 Address Boonsboro, Md

17. Burial Date thereof Oct. 28, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fair-ViewLocation Keedysville, Md

18. Funeral director R. I. Earnshaw  
 Address Keedysville, Md

19. Oct. 27, 1947 John H. Bark  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 19 47 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct. 2 19 45 to Oct. 25 19 47  
 and that I last saw him alive on Oct. 25 19 47

Immediate cause of death Chronic myocarditis  
Chronic nephritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

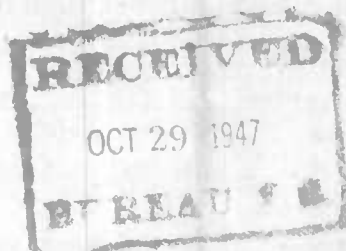
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John H. Bark M. D. or other \_\_\_\_\_Address Boonsboro, Md Date signed 10/26/47

## DURATION

2 yrs. 23 days2 yrs. 23 days





RECEIVED

OCT 18 1947

BUREAU 8



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09452

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 57 years  
 Hospital, institution, or street address where death occurred:  
East Baltimore St.  
57 Years  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. East Baltimore St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS VIRGINIA CATHERINE WILSON

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Charles W.  
 7. Birth date of deceased (mo., day, yr.) February 16 1855  
 8. AGE: Years 92 Months 7 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Keedysville Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home

FATHER 12. Name Sa muel Miller  
 13. Birthplace Keedysville Md.  
 MOTHER 14. Maiden name Elizabeth Ullum  
 15. Birthplace Keedysville Md.

16. Informant Mrs. Noane W. Barnes  
 Address Funkstown Md.

17. Burial 10/17/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Funkstown Cemetery  
 Cemetery or crematory  
Funkstown Md.  
 Location  
Andrew K. Coffman  
 18. Funeral director  
 Address Hagerstown Md.

19. Oct. 15. 19 47  
 (Date rec'd by registrar) Registrar W. H. Powers

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14, 47 19\_\_\_\_ at 2 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-47 19\_\_\_\_ to 10-14-47 19\_\_\_\_and that I last saw him alive on 10-14-47 19\_\_\_\_  
 Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_Cardio Vascular Disease 10/14/47

Due to \_\_\_\_\_

Similarity

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicides, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. W. Powers M. D. or other \_\_\_\_\_Address Hagerstown Md. Date signed 10/14/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 17 1947

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 month

Hospital, institution, or street address where death occurred:

924 Dewey Ave. Hagerstown Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town 924 Dewey Ave. Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 924 Dewey Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Miss Daisy Elsie Young

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1869

8. AGE: Years Months Days If less than one day

78720hrs.min.9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Nurse11. Industry or business Womans Hospital Philadelphia12. Name Jacob A. Young13. Birthplace Frederick Md.14. Maiden name Mary Jane Wolf15. Birthplace Wash. Co. Md.16. Informant Mrs. Harry Krotzer (sister)Address 924 Dewey Ave. Hagerstown Md.17. burial Date thereof Nov. 2-1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. Nov. 1. 47 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 19 47, at 9<sup>23</sup> P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47, to Oct 30 19 47and that I last saw h. er alive on Oct 30 19 47Immediate cause of death Aplastic Anemia

DURATION

12 mos

Due to

Due to

Other conditions Generalised Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. L. Campbell M.D.

M. D. or other

Address Hagerstown Md Date signed Oct 31/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 4 1947

BUREAU 6 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09454

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland..... County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 519 W. Washington St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

ANDREW JACKSON ZEGER

4. Sex..... Male..... 5. Color or race..... White..... 6.(a) Single, married, widowed, or divorced..... Single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... August 11, 1947  
 8. AGE: Years..... 0..... Months..... 1..... Days..... 22..... hrs. .... min.

9. Birthplace..... Hagerstown, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Roy M. Zeger  
 13. Birthplace..... Mercersburg, Penna.  
 14. Maiden name..... Helen Barron  
 15. Birthplace..... Hagerstown, Md.

16. Informant..... Roy M. ZegerAddress..... 519 W. Washington St.

17. Burial..... Date thereof..... Oct. 4 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill CemeteryLocation..... Hagerstown, Md18. Funeral director..... C.M. SUTER & SONAddress..... Hagerstown, Md

19. Oct. 4, 1947..... Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 3, 1947 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 3, 1947 to Oct. 3, 1947  
 and that I last saw him alive on August 15, 1947

Immediate cause of death..... Malnutrition  
 DURATION..... since birth

Due to.....

Due to.....

Other conditions..... Aspiration Pneumonia 1 day

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Ra BeeAddress..... Hagerstown Md. Date signed..... 10-3-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

OCT 7 1947

BUREAU